ON MEDICAID AND MEDICARE MANAGEMENT

The Health Care Financing Administration

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RA
412.4
.P47
1980
June

PERSPECTIVES ON MEDICAID AND MEDICARE MANAGEMENT

JUNE, 1980
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
(HCFA) 80-20021

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INTRODUCTION

The HCFA reorganization created an expanded role for the old Institute for Medicaid Management, now the "Medicaid/Medicare Management Institute" (M/MMI). The Institute continues to provide a forum for exchange of ideas and expertise among States, through conferences and publications, and to maintain a clearinghouse of Medicaid management publications through the Improvements Promotion Division (IPD). IPD staff also conduct Medicaid and Medicare program training for HCFA employees, and coordinate HCFA's interface with the Medicare intermediary and carrier advisory groups.

Perspectives is also sent to Medicare contractors. As our publication's title reflects, we include articles on Medicare operations. We believe that their contributions will enhance the benefits of our publication, since a broader range of ideas and experiences will be shared across HCFA's two major programs, Medicare and Medicaid.

This publication serves as a vehicle for disseminating various State solutions to problems, innovative ideas and articles of general and special interest to State Medicaid managers and staff. We welcome articles on any subject related to either program. We are particularly interested in receiving articles from State agency representatives and Medicare contractors. Responses to previously published material are also welcome.

We see this publication as a joint effort. If it is to be successful, we must have contributions from the States and Medicare contractors as well as their views on how well we are meeting their needs.

Please forward all communications, contributions, requests for information, and materials to:

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TEACHING COST CONTAINMENT TO MEDICAL STUDENTS: THE UNIVERSITY OF OREGON EXPERIENCE

by MICHAEL J. GARLAND, Ph.D.

Introduction

Oscar Wilde once defined a cynic as someone who knows the price of everything and the value of nothing. In this day of unyielding inflation, we are all becoming increasingly concerned by the steady rise of prices in all categories, and, for a great many of us, the price hikes in health care services are extremely perturbing. One proposition that can be put forward without fear of contradiction is that, in the health care industry, many different actors need to collaborate if any meaningful control on health care expenditures is to occur. With that proposition in mind, it may be useful in these pages to review the efforts occurring at the University of Oregon Health Sciences Center to educate medical students about the costs of health care, and how they, in their future careers, may contribute effectively to medical care cost containment programs.

Initiating the Program

In 1977, the Board of Directors of Oregon Physicians Service/Blue Shield (OPS) decided that an important long range investment with cost containment consequences might be made by promoting a medical student educational program at the University of Oregon Health Sciences Center (UOHSC). This approach would differ from the many short term cost containment strategies that have recently been proliferating under the pressure of the times. Medical students are not set in their ways, reasoned the Board, and might be taught to provide medical care not only with technical skill, but with some technological restraint as well. It would be money well spent, it seemed, to instill some cost awareness in the students before turning them loose on the wards.

OPS Board Chairman William C. Scott, M.D. and Plan President Solomon Menashe met with medical school dean Robert S. Stone, M.D. and William A. Fisher, M.D., Professor of Family Practice, to discuss what the school might do with a grant of $100,000 earmarked for cost awareness education.

Several important points emerged from the initial conversations: the program should be designed so that the cost awareness would be presented to the students as an integral part of their full professional competence; cost containment concerns would be related to ethical responsibilities to patients and society; students would be alerted to the fact that elimination of unnecessary procedures and reduction of inefficiency not only reduce costs, but generally reduce inconvenience to patients; and, finally students would be brought to appreciate that the appropriate use of limited resources should benefit those most in need of medical care.

Another important agreement that emerged from the initial considerations was that a direct evaluation of the program's impact on the cost of medical care at the University Hospital and Clinics would not be possible for two reasons: 1) Medical students are not yet independent actors in the health care system and it would be impossible to evaluate their utilization habits as distinct from the influence of house staff and faculty; 2) Only a very elegant, longitudinal, multicenter and costly research project could determine whether the impact of the program was more important in producing cost-conscious physicians than such other factors as the intensity of discussion of cost issues in medical and popular literature, the social background of medical students, the general impact of inflation, or the influence of sun spots on the business cycle. It was agreed that evaluation measures would have to be process oriented and rely on the frequency and appropriateness of the program's contacts with students during their period of training.

The initial impetus from OPS to stimulate a cost awareness program came from the conviction that many different actors must collaborate in order to contain costs in a workable manner.

Insurance carriers, health care providers, government agencies, health plan subscribers, employers, drug companies, medical technology manufacturers, and patients all contribute interactively to the cost escalation in medical care. Any effective cost control will have to involve all of these actors. The cost education program at UOHSC is seen as one piece of a multifaceted effort that needs to occur within the health care market.

As the program began to develop, additional funds were sought from the National Fund for Medical Education. This resulted in a grant from the W.K. Kellogg Foundation of $45,000 mediated by the National Fund. These grants, important as they are to the UOHSC program, signify a growing awareness that action needs to be taken at many levels to achieve socially desirable solutions to the problem of controlling health care costs.

Designing an Educational Program

The UOHSC program rests on two basic assumptions. We assume first that education can be effective to some degree in producing physicians who will allocate medical care resources in a cost effective way. Secondly, we assume that students must see cost containment as compatible with other ideals and responsibilities of the medical profession. These latter include: maintaining quality of medical care, meeting legal and moral obligations to patients, maintaining conditions necessary for progress and innovation in medicine, and promoting the goal of equality of access to needed medical care. We believe that efforts to engage physicians in cost containment activities must carefully respect the constraints implied in the second assumption, if they hope to develop sustained commitment to the effort.

Medical Economics

A basic goal of this program, then, is to lead students to expand their view of the patient-physician relationship to include the economic aspect as well as the interpersonal and technical aspects. They imagine themselves to be moving into a helping profession in which they will perform life saving actions to benefit unfortunate patients. This noble self image, while a true and an important part of the motivation needed to sustain them through an arduous course of training and a demanding career, is an incomplete truth and needs to be rounded out with the perception of the patient-physician relation as an economic transaction also. Medical services must be recompensed or they will not be performed for long. The recompense can come in several ways (fee for service, capitation, salary) and be of several types (financial, social, psychological). What we try to communicate to students is that the economic aspect is part of the picture. It does not negate or sully the "more noble" motivations, but simply accounts for a necessary condition of sustaining the physical energy required for an active career.

A major objective we aim at is for students to appreciate the role of the third party payment mechanism in the flow of recompense and service. When students imagine the physician solely as a provider of services to the needy, the third party payor appears to be an intruder into the special domain of the physician-patient relationship. As they expand their image to include the flow of recompense as an essential part of the transaction, the third party payor, as manager of a pool of resources, appears not so foreign after all. The needs of the third party payor for adequate records and cost containment appear more legitimate. With 60% of doctors' revenue and 95% of hospital income deriving from third party reimbursement,[1] it is essential that students appreciate how and for whom cost containment may be beneficial. As one commentator observed, the traditional fiduciary relationship between physician and patient needs to be reconceptualized to account for the new role of the physician as allocator of resources that have been amassed through taxation or subscription.[2]

The concept of a second fiduciary relationship (i.e., toward the third party payor) is an essential element of the approach to medical students at UOHSC. When they see that the physician plays a crucial role in the way third party resources get allocated, they are able to appreciate the payors' concern over input-output relationships in the production of medical services. The importance of productivity and efficiency in contemporary medical care likewise are best appreciated in relation to the payors' responsibilities to manage a given pool of resources in the best interests of all potential beneficiaries.

By learning to appreciate the perspective of the third party payor (and, by extension, that of the *other* contributors to the resource pool from which a particular patient is entitled to draw)

students are enabled, we believe, to adopt a realistic attitude toward medical care cost containment. System costs for a multiplicity of "small ticket" items are as important as unit costs for a few high ticket items.

This perspective has recently been explored in the *New England Journal of Medicine* by T.W. Moloney and D.E. Rogers, M.D. of the Robert Wood Johnson Foundation, who contend that the conventional wisdom concerning medical care cost control, which focuses on "harnessing the development, diffusion, or use of a relatively few big and costly new technologies," should be replaced by efforts "to make physicians more discerning in their daily use of all technologies."[3] This perspective is, we believe, an extremely important one to convey to medical students. It focuses their attention on precision and competence in the utilization of technologic aids to patient care.[4]

There are, for example, relatively few tests in the array of clinical pathology studies available to physicians at our University Hospital that carry a charge in excess of $20.00. Yet, if an average reduction of $5.00 in laboratory charges per patient day were to occur, the annual savings to the system would be half a million dollars for this hospital alone. Important system savings are available through the competent and discerning utilization of technologic tools by every physician on a day to day basis. Since students do not experience the larger picture in their course of training as clinicians, we feel it is imperative to bring it to their attention both before and while they begin to run up their small share of system costs.

Medical Ethics

When Dean Stone first accepted the grant from OPS for the cost containment education program, he was convinced that important ethical issues are entailed in medical care cost containment decisions, and wanted the program to reflect that perspective.[5] The program has thus been shaped by the conviction that many of the major contraints on simple cost saving proposals are found in the complex individual and social responsibilities that govern the patient-physician relationship. We feel that students will be better prepared to weigh the merits of cost containment ideas if they have spent time reviewing some of these proposals in the light of certain ethical concepts, notably rational self-interest, respect for persons, rights (of patients, families, and health care providers), justice and the common good.

Rational self-interest is the pursuit of personal happiness so balanced that both immediate and delayed satisfactions are functional motives. A truly rational self-interest will also seek priorities among the varied forms of human satisfaction and pleasure that can be part of a medical career. Application of this concept to cost containment issues helps students attend to delayed satisfactions that may be overlooked and, frequently, to draw them back from a too romantic idealism that they really do not hold.

Respect for persons calls attention to the tenet that each person has intrinsic worth which should be reflected in any medical care transaction. Students often find it helpful to test cost containment proposals against the rule that one person should not function in a relationship either as a mere instrument or mere obstacle to another's economic purposes.

The language of rights is very common in our everyday speech, and quite in need of careful inspection from time to time. To have a right, say to health care, may be analyzed in terms of the specific claim on specific persons to provide the health care and/or to finance the required services. Not all claims are justified, and so it is important that students learn to examine the basis for the claim. Some alleged rights really have no rational basis, while among more valid claims it is important that students know which ones are based in specific laws, and which are based in moral principles without the sanction of law.

Like rights, the concept of justice is so commonplace some analysis of its exact use in a given argument can be very helpful. The easiest justice questions are those where it is reasonable to demand simple equality as the norm. However, the health care field is more often an arena of justifiable inequalities, which one must appreciate in terms of capabilities for well being, differing specific needs, contribution to the general welfare of society, special merit, legitimate contract or reasonable recompense.

The idea of the common good or public interest often pops up in discussions of cost and quality in health care. A health-related good is common when it accrues to a whole social unit as a result of social collaboration within that unit. Many goals claimed to be "for the common good" or "in the public interest" need to be carefully looked at by

identifying the group for whom the good is said to be common, specifying the nature of the "good" in question, identifying the direct and indirect ways in which the good is to be redistributed throughout the social whole, identifying the specific costs and primary bearers of the burdens required to produce this good, and finally, considering the good in relation to other goods requiring similar investments of energy, resources, and social will.

Educational Strategy

The educational strategy behind our program has been to look for a number of appropriate places where matters of cost and quality in medical care could be highlighted throughout the required curriculum. (Although the program must eventually include efforts aimed at house staff, we presently focus attention on the undergraduate curriculum.) We currently have developed a configuration of involvement in five required courses and three electives, spanning all four years of undergraduate medical training. This program is deeply indebted to the many faculty members who have found ways to include cost material in a natural way in various preclinical and clinical courses.

We try to use specific cases as the major vehicle for attracting students' attention to the issues and concepts involved in cost containment. While we want them to appreciate the clinical context, where their day to day allocation of medical resources will have the most direct impact for cost containment, we also seek to enlarge their horizons to appreciate the indirect ways in which physicians affect the structures which in turn impact on medical care costs. These structures range from administrative policies in individual hospitals through reimbursement agreements with major third party payors.

Cases and Contexts

The case discussion, a method common both to business schools and ethics courses, presents a concrete situation which requires students to develop and apply both empirical knowledge and relevant values in order to choose a preferred course of action with its probable consequences. The approach is useful in alerting medical students to the multi-dimensional world of health care cost containment. Three examples are briefly reviewed below.

Questions have been raised about the value of using intermittent positive pressure breathing (IPPB) in the treatment of chronic obstructive pulmonary disease (COPD).[6] A multi-center study has been financed by the National Heart, Lung, and Blood Institute to try to settle the controversy, and either satisfy or silence the critics who contend IPPB for COPD patients is a waste of time and money. Many patients like the therapy sessions and say they feel better. Lung function tests show a very transient improvement. Is it an expensive placebo?

The context of this case is clinical, that is, it is a decision dominated by the primary role relationship of physician to patient. The key decision maker is the physician, who must decide on his or her best judgment whether or not to utilize this treatment modality for this patient (or kind of patient). The subject of the decision is a specific therapy. The process is that of patient management.

A case discussion would lead students to elaborate several key economic concepts, and may be used to highlight the impacts of third party payment in dulling the economic "sense" of physician and patient alike. M.D: "Maybe IPPB isn't really worth it, but Joe likes it and he's covered." Joe: "I feel great right after these sessions and, what the hell, I'm covered."

Several other aspects can be highlighted, depending on the students' interests and backgrounds. This case provides a good occasion for students to appreciate the important system savings to be made from small ticket items, if enough units are involved.

Staying with the aspect raised, one can ask whether students feel the physician is bound by any justice obligations to maximize the utility function of any allocation from the pooled resources which "cover" the patient. A similar question might be asked using the common good or the rights of patients as focusing mechanisms.

A second case involves the matter of "do not admit" or "same day" surgery. One study estimated a possible savings of $774 million a year, if the practice were adopted more broadly on a national basis.[6]

This case leads the student to consider another context, that of the physician's workplace, where the primary role relationships are those of the physician with his or her peer group, and with

administrators of the hospital where such surgery would occur. The primary decision makers are the departmental staff and the administrators, who must create the policy and institutional capability to perform surgery this way. The process is that of staff and administrative negotiations.

This case requires students to pick up some understanding of how a hospital functions as an economic institution that has to balance costs and revenues whenever changes in practices are proposed. Other aspects of institutional financial management can be developed in connection with this case.

One might bring the rights of patients or the promotion of the common good to bear on this case, in order to highlight the ethical aspects of the decision. Rational self-interest might also enter in, asking students to consider the relationships between short term and long term satisfactions for physicians and hospital administrators.

A third example relates to the fact that most States require a premarital syphilis screening visit with a physician. In 1979, the Oregon legislature was asked to consider revocation of the required premarital exam, on the grounds that the yield of undiagnosed syphilis cases was too low to justify the outlay of resources to conduct the screen.[7] The Oregon Medical Association urged the submission of the measure and lobbied to have it passed. The measure failed to pass for several reasons, one of them being opposition by a group interested in adding rubella antibody titer and Rh factor screens to the syphilis serologies. Their purpose is to reduce the incidence of mental retardation resulting from pregnancies complicated because of these factors.

In this case, the context is that of the social system in which the physician is related to society at large. The chief actors are political organizations, lobbyists, and legislators. The object of decision is a specific piece of legislation to be enacted through the workings of the political process.

This case yields useful insights into flow of services and recompense within the health care system. Some critics of the syphilis screen suggested that the savings could be applied to other health related projects, such as improved gonorrhea control.[8] In fact, the savings would probably be lost to health services because the screening visit is financed almost universally out of pocket. Money not spent on a premarital visit is more likely to go for champagne than for gonorrhea control.

A primary ethical dimension to be considered here is the common good perspective. Huge total resources are being spent to secure a miniscule benefit that might be equally achieved with other less costly programs.

These three cases have been very briefly sketched here in order to indicate how ethics and economic perspectives can be brought to bear on concrete situations. The approach allows students to develop their understanding via inquiry and problem solving in contexts that are drawn from real world decision making challenges.

Conclusion

We believe that engaging physicians actively in medical care cost containment is an important aspect of dealing with this inflationary sector of the economy. It is likely that the inflationary pressure will be with us for some time to come. Hence, following the wisdom enshrined in the dictum, "As the twig is bent, so grows the tree," it makes sense to focus energy on raising medical students' consciousness about the nature and dimensions of the medical care cost problem. This long range program, we hope, will prepare students to participate constructively with the several other actors in the health care arena to provide efficient medical care without sacrificing quality, violating duties to patients, impeding progress in medical science or increasing inequities in the health care system.

Five basic convictions have been formed in our experience with the program to date: 1) The role of third party payment in contemporary health care must be thoroughly understood by medical students; 2) The legitimate concerns of third party payors for productivity and efficiency must be fully appreciated by students; 3) The limits on cost containment need to be worked out in the light of ethical responsibilities toward patients; 4) The potential for system savings through discerning use of a multiplicity of "small ticket" items should be stressed; 5) Education of medical students (and physicians) will be effective for cost control only if associated with several structural changes in the social institutions comprising the medical care system.

The program described here has many analogues across the country. A 1978 survey by the Association of American Medical Colleges found

that 41 of the nation's 118 medical schools had identifiable programs in quality assurance and cost containment. These programs, we hope, are contributing to the development of a cadre of physicians attuned to the cost problems intrinsic to the American health care system, prepared to take an active role working out acceptable cost containment programs.

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NOTES:

1. In 1977 the exact percentages were 94.1% for hospital care and 61.2% for physicians services. R.M. Gibson and C.R. Fisher, "National Health Expenditures, Fiscal Year 1977," *Social Security Bulletin*, 41,7:7, July 1978.
2. George B. Markle IV, "We Physicians are Fiduciary Failures," *Journal of the American Medical Association* (JAMA), 239,16:1629-30, April 21, 1978.
3. T.W. Moloney and D.E. Rogers, "Medical Technology—A Different View of the Contentions Debate Over Costs," *New England Journal of Medicine*, 301,26:1413-1419, December 27, 1979.
4. This perspective also avoids drawing students into endless debates about how needed but costly interventions might be rationed among desperately ill patients. This latter vision is repulsive to their sense of duty as physicians. Such rationing does occur in the social system because of certain structural barriers to medical care. We try to draw the students attention to these structural problems as well. But we do not want them to equate cost containment with physicians having to make such harsh choices with respect to their patients.
5. Dr.Stone is now Dean of the Texas A & M School of Medicine. His successor at UOHSC, Ransom Arthur, M.D., is similarly convinced of the importance of keeping both the cost and ethics issues simultaneously in focus.
6. "$2 Billion a Year for Useless Lung Therapy?" *Medical World News* June 12, 1978.
7. M.R. Greenlick, S. Marks, A.V. Hurtado, J. Johnson, *"Do Not Admit Surgery,"* Final Report, HCFA Contract No. 600-70-0040. 1979.
8. D.B. Polonoff and M.J. Garland, "Oregon's Premarital Blood Test: An Unsuccessful Attempt at Repeal," *The Hastings Center Report* 9,6:5-6, December 1979.
9. Y.M. Felman, "Should Premarital Syphilis Serologies Continue to be Mandated by Law?" *JAMA* 240,5:459-460, August 4, 1978.

THE IOWA EXPERIMENT: CAPITATION REIMBURSEMENT OF PHARMACISTS

by JOHN T. CIRN, Ph.D.

(EDITOR'S NOTE: *This is the first of two articles describing a project on capitation reimbursement for pharmacists in Iowa. Dr. Cirn's sequel will appear in the next issue of* Perspectives.)

In the belief that an alternative to fee-for-service payment for drugs would be advantageous for the State, patients, and participating pharmacists, the Iowa Medicaid program launched a two year pilot project in capitation reimbursement of pharmacies. Instead of paying per prescription and claim submission, the State paid each of 12 pharmacies in two counties a fixed amount at the beginning of each month for each Medicaid patient who agreed to patronize the particular pharmacy during the month. The experiment ran from July 1, 1976 to June 30, 1978.

Later evaluations of the pilot project by a team of researchers at the University of Iowa[1] revealed that: the pharmacies reimbursed by capitation engaged in a significantly higher average rate of dispensing generic equivalents than did the pharmacies that remained under the fee-for-service system in two control counties; considerable estimated savings in administrative costs were realized by both individual pharmacies and the Medicaid fiscal agent;[2] and almost all the participating pharmacists considered capitation an improvement over the Medicaid program's usual fee-for-service system.

The project was the product of an agreement between the Iowa Department of Social Services and Blue Cross and Blue Shield of Iowa, fiscal agent for the State Medicaid program. Contracts were also necessary between the Department of Social Services and each participating pharmacy.

What follows is a case study on the Iowa capitation project from its conceptualization in 1972 to its termination in 1978. An account is presented of the major events, activities, and administrative and political issues in the promotion and implementation of the program. The author interviewed officials of the Blue Cross of Iowa, leaders of State professional associations, Iowa State government staff, and participating pharmacists.[3] This report focuses on lessons that may be useful in replication of the effort.

An interest in making the pharmacist a more useful member of the health care team was frequently voiced as the groundwork was being laid for this innovation. But the Iowa experience illustrates the principle that role realignment among the health professions does not proceed automatically, in response to technological developments, educational upgrading, or the "self-evident" merits of reform proposals.

The expansion of occupational jurisdictions is very much a promotional enterprise. Accepted scopes of practice are widened only as the result of often laborious efforts to obtain clearances and resources from an array of critical actors. Because of the pre-eminence of the medical profession in the delivery of health care services, "ancillary" professions seeking new practice prerogatives must win the confidence and consent of physicians. Because of narrow conceptions of responsibilities held by some peers, reformers in the vanguard of a profession may have to include their own colleagues among their targets for conversion. Additional constraints are imposed by traditional reimbursement schemes. Not only may a new set of financial incentives have to be created, but also, practitioners may need help in learning what activities—consistent with the highest ideals of their profession—are rewarded by the new payment system.

The Project: Rationale and Key Features

Impetus for the pilot project arose out of a 1972 recommendation by the executive director of the Iowa Pharmaceutical Association (IPhA) that a program be developed for the provision of prepaid pharmacy services to Medicaid recipients on a contractual basis with the State. In conversa-

tions he held with the president and the pharmacy consultant of Blue Cross, several major problems with the Medicaid program were identified as potentially remediable by an alternative to the traditional system of reimbursement of pharmacists.

Of paramount concern to State officials are rising Medicaid drug expenditures, fueled in part by increasing per capita drug utilization among Medicaid patients. Blamed for giving rein to these trends was fee-for-service reimbursement, under which a pharmacist receives payment for the cost of ingredients as well as a professional fee for each prescription filled. This system was viewed as not rewarding pharmacists for activities aimed at cost containment and improvements in the prescribing and taking of drugs. Under fee-for-service, the pharmacist's income is a function of the number of prescriptions filled; overutilization of drugs can increase the profits of pharmacists. It was thus argued that fee-for-service creates a disincentive to better drug management for patients.

Pharmacists in turn were concerned about delays in reimbursement. One study conducted by University of Iowa researchers found that the average time period from filling Medicaid prescriptions to receipt of pharmacy payment was 42 days. This supported the pharmacists' complaints that the time lapse in reimbursement created serious cash flow problems for their businesses. In addition, pharmacists incurred financial losses when claims for services to Medicaid patients were rejected. As one rationale for the pilot project pointed out: "Since categorical indigence is determined monthly in many programs, the pharmacist is often faced with the problem of claims being disallowed because the consumer is no longer eligible for benefits. Claims are also disallowed whenever prescriptions are dispensed for drugs which are not covered by the Medicaid program."[4]

Another frequent complaint is the paperwork burden created by the fee-for-service system. Submitting routine claims entails costs for pharmacists in time, money, and energy. Having to substantiate and resubmit challenged claims adds to these costs and provokes the ire of providers. The processing of claims also generates administrative costs for the reimbursor—costs which could be reduced by a streamlined billing and payments system.

The Blue Cross pharmacy consultant developed a proposal with these key interrelated features: (1) payment by capitation; (2) maintaining patient drug profiles; (3) a patient "lock-in;" and (4) the establishment of community drug formularies and freedom for pharmacists to engage in drug product selection.

Prepayment of pharmacies on a capitation basis seemed one way of relieving the cash flow problems. The idea was by no means new, but it had never been applied to pharmacy services on a broad scale. It was believed that pharmacists would see advantages to regularly receiving a lump sum payment in advance of providing services, instead of waiting weeks or months before being paid, and having to do battle with the State over disallowed claims.

To reduce pharmacists' recordkeeping, yet still meet informational needs of a capitation system, it was proposed that participating pharmacists be required to maintain and submit patient profiles which would serve both professional and administrative purposes. A patient drug profile is a form for listing, by date of issue, the name, strength, and quantity of medications dispensed to a patient, and the charge for each. Ideally, the form also includes information about any known drug allergies or idiosyncracies a patient might have. In this way, pharmacists are expected to fulfill their professional responsibilities to monitor their patients' drug taking patterns, detect possible drug interactions or adverse drug reactions, and bring such potential problems to the attention of the patient or prescriber. Under the fee-for-service system, pharmacists are being asked to record prescription information twice: on patient profiles, for quality assurance, and on claim forms, for billing. But cost and utilization data that could be recorded in drug profiles would also provide third party payors with data for determining future capitation rates and payments. So the pharmacy consultant proposed that capitated pharmacists use a single standardized form as a combination patient profile and billing device, thereby eliminating duplicative efforts and reducing administrative costs. The consultant believed that few pharmacists were using patient profiles, so this project requirement was viewed as expanding the pharmacist's professional role.

As it turned out, all pharmacists who participated in the project were keeping drug profile records on their patients before the project began. Only five of the twelve participating pharmacies used the new form to replace their previous record system for Medicaid patients. The majority of the

pharmacists kept two sets of records during the experiment: their old system that they consulted each time a prescription was filled, and the new system that was used strictly as a billing device. This duplication, then, did not reduce the paperwork burden as intended. (See Figure 1 for form.)

The "lock-in" facilitates the pharmacist's efforts to control drug use. Under a lock-in, a patient is required to designate a particular pharmacy and may not seek services from another pharmacy without giving ample advance notice to the reimbursing agency. A lock-in, while essential for the financial health of a capitation system, also makes possible the consolidation of a patient's prescription drug history, and gives the pharmacist a more complete overview of drug utilization patterns.

Pharmacists who participated in the pilot project agreed that this feature enriched their professional activities. But, as will be described later, enforcing the lock-in turned out to be one of the biggest administrative headaches in the experiment.

Capitation had appeal not only for the potential to reduce administrative costs, but also for the new set of financial incentives created, to try to reduce drug therapies costs.

> Inasmuch as the prepaid project shifts the determinant of a pharmacist's revenue from the number of prescriptions dispensed to the number of patients on his/her patient roster, one would anticipate that the pharmacist would attempt to lower dispensing costs. This may be manifested by (i) switching to non-prescription drugs; (ii) changing the type of drugs dispensed by therapeutic category; (iii) changing the quantities of drugs dispensed per prescription; (iv) shifting to lower cost generic equivalents; (v) changing the drug dosage regimen; (vi) changing patient consultation practices; (vii) intercepting drug interactions.[5]

To the Blue Cross pharmacy consultant, the major way that pharmacists under capitation could make an additional profit and at the same time save money for the Medicaid program was by substituting lower cost generic equivalents for expensive brand name products. However, at that time (1972-1973), the movement to repeal "anti-substitution laws" was in its infancy, and Iowa was one of the many States that prohibited pharmacists from substituting another brand of a drug entity for that specifically indicated on the prescription. To address this, the physicians were approached community by community and persuaded to allow local pharmacists to make generic substitutions. To facilitate this grant of discretion, it was proposed that pharmacists be limited in their substituting to products listed on local formularies jointly established by the physicians and pharmacists.

As it turned out, the formularies were never developed. The Iowa State Legislature amended the Pharmacy Practice Act to permit the pharmacist to substitute a generically equivalent drug (unless the physician has specifically ordered that the prescription be filled as written). That law's effective date (July 1, 1976) coincided with the beginning of the pilot project.

The new financial incentives apparently had their intended impact. There was a substantial increase in the rate of generic substitution in the experimental counties, far in excess of the increase in a pair of control counties, where the pharmacies remained under fee-for-service. However, there was also considerable variation among the capitated pharmacies, with several making no more generic substitutions than the average pharmacy in the control counties.

The Campaign at the State Level

This section traces the course of the capitation proposal through Blue Cross of Iowa, the Iowa Department of Social Services, the Iowa Pharmaceutical Association, the Iowa Medical Society, and the State Comptroller's Office.

According to an official with the State Department of Social Services, there is not much incentive for Blue Cross of Iowa, as the Medicaid fiscal agent, to undertake cost saving experiments like the capitation project. This, he believes, is due to the cost reimbursement terms of its contract with the State, and the lack of any real competition for the contract. There will be competition from other carriers in the future, however, and having a record of involvement in projects like the capitation experiment will give an advantage to Blue Cross.

The contract making Blue Cross and Blue Shield of Iowa the fiscal agent for the State's Medicaid program included a rare provision requiring Blue Cross to hire a pharmacist consultant. To this man must go much of the credit for the conceptualization, promotion, and implementation of the Pharmacy Capitation

FIGURE 1: Patient Drug Profile Record Form

Case Number: _____ Month_____ Year__

Patient Name: _____
Last First Middle Int.

Address: _____ Phone: _____ Birth Date:_____ Sex____

Place of Residence: SNF ☐ Nursing or Custodial ☐ Other ☐ Pharmacy Name:_____

Pharmacy Number:_____

Drug Sensitivities 1) _____
2) _____
3) _____
4) _____

MONTHLY MEDICATION HISTORY

Date Dispensed	Drug Name and Strength	Drug Code	Dosage	Quantity	Drug Cost	UCR Charge	Physician Name & Number

Pharmacy Comments:

Physician Comments:

For Physician Review (3rd Copy Only)

Pilot Project. He received ideas and encouragement from faculty members of the University of Iowa College of Pharmacy who would later lead a research team in an evaluation of the project.

His success was due in part to the rapport he had already achieved with the State's pharmacists through his dealings with them, including a position as a membership recruiter with the State pharmaceutical association. Almost all the owner-pharmacists later indicated that the efforts of the project manager made a big difference in their decision to participate in the experiment. The head of the university-based evaluation team also observed that someone like him was needed at Blue Cross, "Someone closely associated with the project who will closely monitor it, relieve the apprehensions of the pharmacists and give them someone they can directly relate to."

Facilitating Blue Cross interest in the pilot project was its record of harmonious collaboration with the Iowa Pharmaceutical Association in the development of the Iowa Pharmacy Service Corporation (IPSC). This non-profit mechanism for third party prepayment of pharmaceutical services is unique because of the role played by pharmacists in its establishment and professional direction, and because of its success in the marketplace. The latter is attributed to the administrative, fiscal, and marketing services provided by Blue Cross under contract. Although the president of Blue Cross also serves as president of the IPSC, the IPSC has its own board of directors, and its prepaid programs can be sold to groups separately from Blue Cross/Blue Shield packages.

The IPSC was incorporated in 1967, but its growth was slow until the 1972 arrival of a new Blue Cross/IPSC president, who had previous experience in third party prepayment of prescription services. As a result of the aggressive marketing effort he stimulated, the IPSC grew rapidly, until in 1977 it had over 75,000 contracts, covering over 450,000 people and made benefit payments totaling $2.67 million. It is his belief that the prior existence of the IPSC unquestionably "smoothed the way" for the Capitation Pilot Project because it gave Blue Cross additional experience in handling prescription drug benefits and because it reinforced the good relationship that Blue Cross enjoyed with the State's pharmacists.

The IPSC, as well as any organization by pharmacists, must step carefully when it becomes involved in capitation reimbursement schemes. Such involvement may face legal challenges on antitrust grounds. This was a lesson learned by the IPSC sponsors when they sought from the U.S. Department of Justice "business review clearance," an opinion as to whether their efforts might be subject to criminal antitrust litigation. The IPSC articles and by-laws, and the participation agreement between the IPSC and pharmacists, had to be rewritten twice to remove objections raised by the Federal officials. The reimbursement method had to be specified, and the Justice Department indicated that if the IPSC changed the method from "usual, customary, or reasonable," the clearance would not stand and another review would have to be obtained. The Justice Department gave no hint that it would disapprove of a capitation system, but it said that it wanted to be notified of any proposal for a change in reimbursement mode.

The Blue Cross president also recalled legal obstacles he faced in his former position with Blue Cross of Wisconsin. He had worked with that State's pharmaceutical association to establish a prepaid prescription service for Blue Cross employees. The program had to be terminated after four months when the Justice Department challenged it as a violation of the Sherman Antitrust Act. As the Blue Cross official put it, "Had we arrived at the reimbursement formula unilaterally, it would have been all right. But we made the serious mistake of working on it with the pharmaceutical association."

A warning thus emerges for promoters of capitation reimbursement plans: the assistance and endorsement of provider associations may be valuable or even indispensable, but, until the position of the Justice Department relaxes, provider groups must tread cautiously in rate-setting fields or they may run afoul of antitrust laws.

The president and board of Blue Cross supported the pilot project proposal, but they did not anticipate a dramatic reduction in costs. They felt the experiment would be worthwhile if it did no more than break even financially. The Blue Cross president was especially interested in the ways that the project might lead to more involvement of pharmacists with physicians in drug product selection and in the coordination of drug therapy. He believes that, for health professionals, the persuasive selling points for such reform proposals as the pilot project are their prospects not for additional financial gain, but for a higher

quality of care or more effective use of one's time.

The Medicaid Agency: The pharmacy capitation proposal was also well received by Medicaid officials at the State Department of Social Services (DSS). But here again, as one key official recalled, there was not much hope for substantial cost reduction, at least at the pilot stage. The participating pharmacists were guaranteed in their contracts that they would receive no less money "than would have been received under the current fee-for-service mechanism of reimbursement." At the same time, Blue Cross assured the Department that the State would incur no increased costs because of the project. If additional costs did arise, Blue Cross and the IPSC promised to bear them. Moreover, the project required only the approval of the Department and a very limited amount of administrative assistance from its staff; the implementation would be handled largely by Blue Cross.

The principal selling point for the State was that it would be relatively easy to budget for a capitation program because the financial commitment was determined in advance—*if* the number of recipients in the program could be predicted with reasonable accuracy.

The Blue Cross president and the project manager first presented the proposal to the medical consultant to the Department's Medical Services Section; he viewed it as worthwhile and raised no objections. Thereafter, the Blue Cross project manager dealt principally with the Department's pharmacy consultant, who presented the proposal to other administrative staff and secured the approval of the DSS Commissioner. This pharmacy consultant recalled that the higher up one went with the proposal, the more concern there was with its fiscal dimensions. But middle managers were also interested, as he put it, "in seeing better use of the pharmacist, closer contact with patients, and more cooperation and consultation with physicians."

Next the Medicaid agency had to secure approval of the project from the Medicaid Regional Office, HEW.* This approval was obtained without difficulty and hinged on the State's assurance that no more expenses would be incurred for the Medicaid program than under traditional fee-for-service. The regional office notified the Iowa DSS that the pilot project was discussed with the HEW central office, and "it is felt that the project would be eligible for Federal financial participation as long as normal eligibility, utilization review, and cost effectiveness standards are maintained."

Interestingly, one of the arguments advanced to win State endorsement was that the capitation project would eliminate the money and efforts spent on utilization review. "The responsibility for proper utilization review," said the project manager, "would fall where it should, on the pharmacist's shoulders, and there would be no need to see what he did."

The State was unable to muster the resources needed for a careful evaluation of the pilot project. This task was assumed by the university research team, with funding from HEW.

The pilot project was originally intended to be one year in duration. While the project manager collected data during the experiment showing dispensing trends in the two capitated counties, he realized he had no comparable data from control counties. He requested an extension of the project for another year when University of Iowa researchers prepared a grant request for an evaluation of the project. (The research design included plans for a systematic collection of data from pharmacies in two counties remaining under fee-for-service.) The project was extended quarter by quarter for a second year as funding of the research proposal was awaited.

The project director reported to the State that his reviews of the patient drug profiles indicated that the generic substitution process was increasing month by month. The State terminated the project on June 30, 1978, to await the findings of the evaluation study. According to the DSS pharmacy consultant, if this evaluation showed the capitation program's potential for better service to beneficiaries, greater satisfaction of pharmacists, and reduction in overall benefit costs, the Department of Social Services would be receptive to proposals for continuation and expansion of the project.

After approval for the proposal was obtained from Blue Cross, the IPSC, the Iowa Department of Social Services and HEW, it would have been possible to take the proposal directly to individual pharmacists and physicians. The project manager, however, believed that failure to first secure the endorsement of the State professional associations might arouse the suspicions of providers in the field and create a serious obstacle in gaining their consent to participate.

*Now the Department of Health and Human Services.

The Pharmaceutical Association: The first hearing for the proposal came in 1973 at a meeting of the Interprofessional Activities Subcommittee, a joint committee of the Iowa Pharmaceutical Association (IPhA) and the Medical Society. This body approved, in essence, the early plans for the project.

The IPhA executive secretary proposed that organized pharmacy undertake experiments in providing prepaid services to Medicaid recipients on a contractual basis with the State. Blue Cross presented a preliminary draft on the proposal to the IPhA Executive Committee. Approval was sought for the concept and for plans to approach individual pharmacists and physicians in selected counties to discuss the project.

The proposal was defended as a means for pharmacists to better use their skills and knowledge, through greater interaction with patients and physicians, in order to improve drug utilization and reduce total costs. It was further pointed out that this was to be a test of a mechanism for increasing pharmacists' acceptance of governmental prepaid programs in both the public's and the profession's interest. Only the broadest references were made to the capitation feature.

While a few members of the Executive Committee raised questions, the general reaction was favorable. The committee members were impressed by the prospect of eliminating the delays and hassle of the fee-for-service process. No objections were raised to the recordkeeping requirement; an estimated 75 percent of Iowa pharmacists were already using a patient profile to varying degrees. The committee was not hopeful at that time, however, about the rank-and-file accepting the proposal for a local formulary. Only when the IPhA began vigorous efforts to repeal the antisubstitution law did many pharmacists come to realize the merits of that feature.

Here and in later deliberations, difficulties emerged among the IPhA leadership in comprehending the capitation concept. The conviction was widely shared that pharmacists, in Iowa and throughout the nation, had never been equitably compensated by Medicaid. Some IPhA members feared that pharmacists would lose money under capitation, that the proposed scheme was just another way for the State to pay less. The new financial incentives created by capitation were a nebulous concept. Many IPhA members thought that capitated pharmacists would receive payments only for those Medicaid recipients who brought prescriptions to fill; they had trouble understanding that capitations would be paid for every eligible recipient whether services were provided or not. It was necessary to emphasize the fact that less than 40 percent of the recipients eligible for benefits in all aid categories were actually obtaining prescription services.

At the beginning, there was acute concern at the IPhA that pharmacists serving many nursing home residents, who are especially heavy users of prescription drugs, would be severely disadvantaged if a single flat rate was paid for each Medicaid eligible. Later presentations had to make it clear that separate capitation rates would be established for different aid categories, and that these rates would reflect the differences in utilization revealed by historical claims data.

The Blue Cross Pilot Project manager presented the proposal in general outline to the IPhA House of Delegates in November, 1973. After little discussion, they approved the project in principle, pending refinement of the plan, and conditioned on the approval and cooperation of the pharmacists in the selected counties.

The Medical Society: The stormy passage of the pilot project proposal through the Iowa Medical Society (IMS) began on a good note: it was favorably received by the Society's Interprofessional Activities Subcommittee. This body was chaired by a physician who helped found Iowa Blue Shield and who became a champion for the proposal in later Medical Society deliberations.

However, the first attempt to win the approval of the IMS House of Delegates met with failure, sending the proposal into a state of limbo for a year. Only after certain innovative features were deleted from the original proposal did the Medical Society endorse the plan in concept.

The presentations to physicians, at both the State and local levels, focused on their participation in only two features of the pilot project:

1. Working closely with other physicians and pharmacists in the county on developing local drug formularies which would list their selections as to clinically equivalent drug products, from which the pharmacists would be able to substitute in filling prescriptions; and
2. Doing monthly reviews of medication profiles for selected Medicaid patients where

potential problems regarding drug use had been detected.

In the appeal to physicians, emphasis was placed on winning their consent to allow participating pharmacists to dispense generic equivalents. (Recall that this presentation to the Medical Society preceded by some time the repeal of the State antisubstitution law.) Physicians' fears of loss of autonomy had to be addressed. The second (and successful) report of the Interprofessional Activities Subcommittee to the IMS House of Delegates said that the committee "was assured it is not the intent of the project to establish a hard and fast formulary, nor to usurp the right of the physician to prescribe whatever he (or she) wishes and feels is best in any situation."

The second feature of the project, physician review of drug-taking histories for particular patients, was an improvement in interprofessional communications the capitation system would hopefully stimulate. In theory, under capitation, it is in the pharmacist's financial interest to intercept drug interactions and improper dosage schedules whenever possible. Patient illness exacerbated by or resulting from these errors may generate more drug therapy; the consumption of more prescription drugs by a patient will increase the prepaid pharmacist's expenses without increasing revenues. A capitation system, as the argument goes, should increase the pharmacists' motivations to monitor more closely patient drug profiles, and bring potential problems to the attention of physicians.

To facilitate this pharmacist/physician communication, the patient drug profile form was developed in triplicate. One copy was kept by the pharmacist, and two copies were sent on a monthly basis to Blue Cross. It was originally planned that at Blue Cross, the pharmacy consultant would review the profiles and, where there appeared to be a drug interaction problem or misuse on the part of the patient, forward a copy to the physician. The physician was expected either to take corrective action, or note approval of continuing the regimen in question, then return the profile to the pharmacy. As the report to the Medical Society stated, "this mechanism would provide the physician with a means of quickly reviewing each patient's drug history as well as a convenient means of communicating with the pharmacist concerning changes in that drug profile."

The project director recalls that physicians complained that they did not want to be burdened with this additional paperwork. The project director explained that profile copies would be sent to them only if a problem appeared. But as it actually turned out, the project director never made that judgment and never did anything with the second copies, due to a lack of time.[6]

A dominant theme in the presentation to physicians, at both the State and local levels, was the inevitability of a greater role by pharmacists in drug product selection, and the value of individual communities developing their local formularies to prevent the imposition of an undesirable Federal formulary. Presentations referred to testimony by the HEW Secretary proposing "lowest cost" reimbursement for drugs, a proposal said to be giving great impetus to the campaign to repeal State antisubstitution laws. The project should "demonstrate that the pharmacist can assist the physician in the development of more effective drug product selection standards. Further, the project hopes to demonstrate that these standards can be best established at the community practitioners' level rather than by some directive originating at the State or national level."

Other brief references were made to the widespread misuse of drugs and the number of deaths and injuries resulting from adverse drug reactions. It was argued that these adverse effects could be prevented by the review of patient medication profiles, part of the pilot project.

Neither alarms about impending legislation nor arguments on the merits proved to be persuasive when the proposal first reached the floor of the IMS House of Delegates in October 1973. The House followed the recommendation of its reference committee and, with little debate, refused to endorse the pilot project.*

The IMS House's rejection in this first round was formally based on objections to two administrative features in the original proposal. Only when these features were eliminated did the Medical Society give its approval to the project.

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*(At annual meetings of medical societies, resolutions are typically debated before one of several small reference committees composed of member-physicians, before being brought to the general assembly for further brief discussion and a vote. A reference committee's recommendation for or against House approval of a resolution carries great weight with the delegates and is rarely not followed.)

The first objectionable provision would have required "pharmacists to be knowledgeable regarding the patient's primary diagnosis and drug idiosyncracies." The plan was to ask physicians in the experimental counties to routinely write the diagnosis or other helpful information about the patient's condition on the prescription blank. This was viewed by the project manager as critical to enabling the pharmacists to make better use of their expertise to improve drug therapies. "We felt there was overriding need for the pharmacist to have information about the patient's problem so they could make judgments as to the appropriateness of medications." Blue Cross was not interested in obtaining diagnoses for utilization review purposes, nor did physicians express concern that this information might be used for such purposes.

The project manager acknowledged that there was both valid and invalid reasons for the physicians' objections to this provision. A major concern of the physicians, and the reason the Medical Society put forth, was confidentiality of privileged information. Also central to the motivation of the doctors, in the estimation of both the project manager and a spokesman for the IPhA, was the doctors' aversion to having their professional judgment opened to challenge by the pharmacist. IMS officials, however, said that no objections to the proposal on this ground were openly expressed by the physicians.

Other possible grounds for the physicians' distaste for this proposal are the difficulty in sometimes specifying a diagnosis, fear of malpractice suits if the diagnosis later proves to be incorrect, unwillingness to let some patients know the diagnosis, and simple unwillingness to take time away from a busy schedule to make this notation.

The second feature which the Medical Society found objectionable was one requiring "a monthly review by the pharmacist, with the physician, of each patient's medication history." Physicians objected because they believed such meetings would mean too much time and trouble. This requirement was replaced by the plan, described earlier, of simply sending problem profiles for optional review.

When each capitated pharmacist was asked about the idea of regular periodic conferences with physicians to discuss patient therapies, there were more than twice as many pharmacists opposed as in favor. Most pharmacists in opposition stated that they already had sufficient opportunity to discuss individual cases with physicians, as necessary. There was widespread support, however, for the proposal of having occasional meetings attended by all pharmacists and physicians in the area to discuss general problems or therapies.

Key promoters of the project believed that the Medical Society's initial rejection of the proposal was really motivated not by the publicly stated objections to details, but rather by tacit resistance to the more fundamental concepts of generic substitution and to capitation.

Despite the fact that there were no concerns officially expressed by the Medical Society over the capitation feature, the project manager thought that physicians feared that the project would be a "foot in the door" to eventual capitation schemes for physicians' services. He believes that the mistake he made in his 1973 approach to the Medical Society was "to go into some details as to what would happen under the project." He then made what may well be one of the most important—and debatable—decisions of his campaign. He decided to avoid mentioning the capitation feature to physician audiences, or describing how the pharmacists would be reimbursed. He took the position that the capitation feature was a "side issue, of no bearing to the involvement of physicians," and that nothing would be gained by "waving this red flag" before them. Later presentations to the Medical Society and to physicians in the counties made general references to attempts to resolve some of the pharmacists' payment problems, and may have included mention of the lock-in and the plans for prepayments to pharmacists, but deliberately avoided details on the plans for capitation of pharmacists.

Blue Cross staff felt that it could not proceed with the pilot project without the endorsement of the Medical Society. At subsequent meetings with the chairman of the Interprofessional Activities Committee, the project manager cleared up some points and removed the provisions found objectionable by the Medical Society.

The revised proposal was presented to the Medical Society at the 1975 meeting of its House of Delegates, which took action "to approve, in principle, the general concept of the proposed project with the understanding that authorization be obtained from affected county medical societies prior to implementation."

The State Comptroller: A potentially troublesome barrier arose in an unexpected place, the State Comptroller's Office. The individual in the Comptroller's office in charge of Department of Social Services funds, acting to protect the State's money, objected to two details of the financial mechanics of the project proposal.

As the sequel article will describe in more detail, the calculation of the capitation rates involved extrapolations based on previous average monthly drug costs per eligible Medicaid recipient. Only ninety percent of these per capita costs, however, would be taken as the monthly capitation rates paid to participating pharmacies. The remaining ten percent were to be withheld and placed in an escrow account. From this escrow account, supplementary payments would be made to those pharmacies with total monthly capitation payments short of what they would have received had they remained under the fee-for-service system.

The comptroller insisted that the escrow monies be kept in a trust fund within the State Treasurer's control instead of Blue Cross' bank. This would allow the State to collect the interest earned on the reserve funds, and to make a complete accounting of the money. Whenever Blue Cross had to make supplementary payments to pharmacists, it had to request a transfer from the State trust fund.

The second problem was with the plans for using State funds for prepayment of services. The comptroller said that this was illegal according to State law.[7] It was the policy of the State, with few minor exceptions, to pay for goods and services only after delivery and receipt of an invoice. To get around this problem, it was necessary for Blue Cross and Blue Shield of Iowa to make the capitation payments to the pharmacists on the first of the month out of its own regular business funds, then send a voucher to the DSS requesting an amount to cover these payments, with the expectation that Blue Cross would be reimbursed by DSS by the end of the month. In actuality, Blue Cross had to dip into its own funds temporarily only for the first month's payments to the pharmacies; it recovered these funds with the State's final check sent in the month after the termination of the project.

Because of possible objections to using Blue Cross subscribers' funds to pay for Medicaid benefits, the project manager touched base with the State Insurance Commissioner, who is responsible for seeing that all laws concerning the insurance business are enforced. The Insurance Commissioner indicated no objections would be raised to the proposal, provided that Blue Cross was reimbursed on a monthly basis by the State, and that any interest or carrying charges created by that mechanism would be paid by Blue Cross subscribers. The interest lost by the Blue Cross commercial business reserves would be recovered from funds obtained from the State for administration of the Medicaid program.[8] The Insurance Commissioner's Office also wanted to be sent copies of the monthly reports that Blue Cross submitted to the DSS.

This procedure operated to everyone's satisfaction only because of the limited scope of the pilot project; the involved parties would not permit significant expansion. A relatively small sum, about $17,000 a month, was required for payments to only 12 pharmacies. In future, an alternative arrangement will have to be developed for any major expansion of the project, since Blue Cross does not have the funds to support a Statewide application of a capitation plan.

(In the next issue, the selection of experimental counties, local monitoring of the project, the lock-in program and capitation rate setting will be described.)

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NOTES:

1. These investigations have been supported by a grant from the National Center for Health Services Research, project number 5 R18 HSO2658-02 HSDG, funded March 1, 1978. The co-principal investigators are G. Joseph Norwood and Charles Yesalis. Early findings are summarized in G. Joseph Norwood, *et al.*, "Experiences with Capitation in the Iowa Medicaid Drug Program," mimeo, Health Services Research Center, University of Iowa, April 19, 1979.

2. For more detailed reports, see Charles R. Standridge and Narasenga B. Rao, "Cost to Pharmacies of Filing Iowa Medicaid Drug Program Reimbursement Claims: A Case Study;" and Robert Capettini and Gerald Myers, "Fee-For-Service vs. Capitation: An Analysis of Administrative Costs Under the Iowa Medicaid Drug Program." Both reports are available from the Health Services Research Center, University of Iowa.
3. The pharmacists' responses are reported in John Cirn, "Pharmacists' Views of an Experience in Capitation Reimbursement Under the Iowa Medicaid Drug Program," mimeo, Health Services Research Center, University of

Iowa, May 1979. An abbreviated version will be published in *Contemporary Pharmacy Practice*.

4. Project narrative of research proposal, "Capitation for the Iowa Medicaid Drug Program," for grant cited in fn. 1.
5. *Ibid.*, p. 11.
6. Weaknesses in this plan for physician review of patient profiles were pointed out in an HEW critique of the grant proposal for evaluation of the pilot project. The proposal reviewers wrote:

   > How can physicians review the last month's list of medications of patients for whom some other physician has done the prescribing and, without examing the patient, evaluate the appropriateness of continuing that regimen for another month? What is likely is that extreme cases will be tagged, but if the pharmacist's drug profile is maintained, as suggested, adverse interactions should be noted there and at the beginning, that is, at the time the prescription is written and not one month later.

7. He cited chapter 8, sections 14 and 15, of the Code of Iowa, as the basis for his decision.
8. The pilot project also posed the problem of how Blue Cross was to determine what it was owed by the State for administering this part of the Medicaid program. Blue Cross normally billed for administrative costs on a per-claim basis. The project manager, in his monthly analyses of the profile sheets submitted by the capitated pharmacies, had to make a claim count which was entered into Blue Cross' bill to the DSS for reimbursement of Medicaid administrative costs.

SUPPLEMENTARY INSURANCE TO MEDICARE—TWO VIEWPOINTS

On June 9, President Carter signed into law P.L. 96-265, "The Social Security Disability Amendments of 1980." That Act contains a provision which requires HHS to establish a voluntary certification program for Medicare supplemental policies, popularly referred to as "Medigap" insurance. This voluntary program applies to States that do not specify minimum coverage standards for Medicare supplementary policies.

In the next two articles a U.S. Senator and a Health Insurance Association of America attorney present different perspectives on the Medicare supplementary insurance issue.

MEDICARE SUPPLEMENTARY HEALTH INSURANCE: BADLY NEEDED REFORM ON THE WAY

by SENATOR MAX BAUCUS,* (D-MONTANA)

Introduction

Older Americans are living with a very real fear. These elderly citizens are afraid of being ill and not being able to afford care. Sadly, it is a legitimate fear. Health care costs are escalating at an alarming rate—from $12 billion for health care in 1950 to $162 billion in 1977—a rate of 1250 percent. For the senior citizen living on a fixed or limited income, health care costs can go on beyond simple inflation to financial devastation.

Fear of financial devastation has left these senior citizens vulnerable to unscrupulous sales pitches and unethical contracts. Older Americans do have Medicare, but today it pays for only 44 percent of a senior citizen's health bill. Medicare's statute also limits the kinds of services covered and sets requirements for beneficiaries to obtain services. This coverage is not as comprehensive as most older Americans believed it would be when Medicare legislation passed in 1965.

In order to fill the gaps in Medicare, older Americans are buying supplemental, or Medigap, health insurance policies. More than 15 million Americans or about two-thirds of the elderly population have purchased at least one Medigap policy, Congressional investigations have shown.

Exacerbating the situation are those unscrupulous, "fly-by-night" insurance salesmen who are trying to sell senior citizens worthless, duplicative coverage. The result is that senior citizens are buying the same coverage over and over at greater and greater cost. Some of these supplemental policies return less than 50 cents in benefits for each dollar in premiums that the older person pays.

Since 1970, Congress has held hearings and investigations to document numerous and widespread abuses in the sale of Medigap policies. Congressional concern over the extent of these abuses has led to the efforts to find a remedy.

*The author wishes to express special gratitude to Deborah Landau for her work in helping to research and prepare this article.

Documenting the Problem

Since 1971, there have been 19 studies conducted of Medicare supplementary health insurance offered by private insurance companies.[1] These studies confirm that Medigap abuse is, indeed, a national problem. In addition, they demonstrate that few States have taken action to prevent senior citizens from being sold multiple and duplicate—thus essentially worthless—insurance policies.

The House Select Committee on Aging conducted an exhaustive investigation in 1978, examining the practices of more than 60 insurance firms specializing in the sale of Medigap policies to senior citizens.[2] The committee report documented widespread fraudulent practices in the Medigap area.[3] The House investigation revealed that the elderly are easy victims for aggressive and unscrupulous sellers of insurance:

- An elderly woman was sold 11 policies by one company in the last three years, with three currently in force. Total premium payments were over $2,500.
- A 76-year old senior citizen was sold 13 different life and health insurance policies from 7 agents during a two year period. These policies cost over $9,000 a year in premiums, or 68 percent of her income.
- A Florida couple, age 82 and 78, delayed repairing their refrigerator and stove because they were trying to keep up with $2,882 yearly premiums on 19 separate policies.
- An 80-year old Pennsylvania woman spent over $50,000 on 31 policies over three years. To make payments, she took a $3,000 loan from her bank.

These are just a few examples through which Congress documented a growing problem. These

citizens are buying what seems an inordinate amount of coverage, but rarely does the addition of numerous policies increase the actual insurance coverage for them.

Indeed, the House Select Committee on Aging estimates the loss to senior citizens may be $1 billion a year. Investigations, reports and hearings conducted by the Senate Special Committee on Aging and the House Select Committees on Aging have documented a decade of abuse in the sale of Medigap policies to the elderly. What have we learned from these disclosures?

First, senior citizens receive confusing information about the scope and extent of the coverage provided.

Second, unethical sales agents prey on the fears of the elderly. Senior citizens are made to believe that the solution to inadequate health care coverage is to buy more and different policies, yet often these additional policies provide little or no protection.

Third, restrictive benefit clauses often make the policies financially unattractive, when viewed in terms of premium cost to actual amount of coverage provided.

Finally, complex policy language makes it difficult, if not virtually impossible, for consumers to make informed and intelligent choices about the policies they wish to purchase.

Senior citizens, like most Americans, are uninformed about insurance. An insurance policy is a "blind item." Senior citizens have little information to use in judging the value of what they are purchasing, and thus tend to accept insurance agents' representations, as do most citizens. Yet, some of these policies stipulate in complicated terms that a person holding more than one such policy can benefit from only one of those numerous policies.

While some Americans are sold policies that merely duplicate insurance they already hold, others are sold Medigap policies with so many loopholes that they return as little as 20 cents for every dollar invested. Confusing and misleading information about policies makes it virtually impossible for any consumer to make intelligent and informed purchasing decisions.

Coupled with the poor economic value of many Medigap policies are fraudulent or abusive techniques used by many agents to exploit Medicare beneficiaries. These practices have generated their own vivid vocabulary.[4]

One technique is known as "twisting" or the "rollover." Under this technique, an agent persuades Medicare beneficiaries to cancel their current insurance, and to replace it with whatever the agent is selling. High first year commissions—65 percent is typical and 100 percent is not unknown—provide an incentive to engage in twisting.

Among other practices identified during Congress' investigation is that of "loading up." Agents use this technique to convince people that their present coverage is inadequate, and then sell them extra policies to fill so-called gaps. The result is worthless duplication—with needless premium costs and little coverage to show for these costs. We believe that 23 percent of those who buy Medigap insurance have some duplication in coverage. In fact, the 1978 report of the House Select Committee on Aging disclosed that these unethical sales practices result in tragic situations where older Americans purchase two, three, four and, in one case, as many as 90 duplicative and worthless Medigap policies.

Another technique used in selling supplemental policies is known as the "wolf in sheep's clothing." This occurs when an agent fails to mention that he or she is selling insurance, and often gives the impression that he/she is from Medicare.

These fraudulent and abusive practices are common, we found. Lively scandals have emerged in 23 States and the majority of State insurance departments have characterized Medigap marketing abuses as a major problem in their States. Yet, despite the hundreds of case histories made public through Congressional hearings and the media, by the end of 1979, only a handful of States had taken comprehensive and corrective action to address this situation.

Most States report they have not disciplined a single insurance agent for abuses in the sale of health insurance over the past five years; four States alone account for 60 percent of all licenses revoked over this period.

While the insurance industry asserts that at least 30 States have taken steps to remedy Medigap abuses, these activities in fact have ranged from holding a hearing, to issuing a brochure, to having a study underway.

However, a study recently published by George Washington University reports that only 18 States have laws or regulations affecting the sale of

policies supplementing Medicare.[5] Only nine States have adopted minimum standards for Medigap policies, and more significantly, only seven States have established regulations setting loss ratios for these policies.

State activities have been inadequate at best. For all these reasons, several Members of Congress confronted the problem and designed legislation that supports and encourages State regulation, while at the same time, protects senior citizens from further exploitation.

The Medigap Legislation

Despite stiff opposition from the private insurance industry, Congress has passed legislation to reduce abuses in Medigap practices. The legislation (P.L. 96-265) requires the Secretary of the Department of Health and Human Services (HHS) to certify Medigap policies that meet certain minimum standards. The program, which would be voluntary in nature, covers States that do not apply equivalent or higher standards for Medigap policies. This legislation will give the elderly the basic tools to make informed purchasing decisions and should eliminate much of the confusion over the range of policies available.

Under the voluntary certification procedure, insurance companies could submit Medigap policies to the Secretary of HHS for evaluation. Using criteria set out in the legislation, the Secretary would certify that the policy meets standards prescribed by the National Association of Insurance Commissioners for Medicare supplementary policies. Several criteria have to be met in order for supplemental policies to be certified as meeting minimum standards.

First, a policy would have to meet specified standards with respect to coverage of Part A (institutional services) and Part B (physician services) under Medicare. Such policies must provide:

- coverage of Part A Medicare eligible expense for hospitalization to the extent not covered under Part A from the 61st day to the 90th day in any Medicare benefit period;
- coverage of Part A Medicare eligible expenses incurred as daily charges during use of Medicare lifetime hospital inpatient reserve days;
- upon exhaustion of all Medicare hospital inpatient coverage, including lifetime reserve days, coverage of 90 percent of all Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days; and
- coverage of 20 percent of the amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year.

Second, supplemental policies could not limit benefits for more than an initial six-month period because of a health condition existing before the policy was effective.

Third, policies must prominently display a "no-loss" cancellation clause enabling the consumer to return an agent-delivered policy within 10 days without financial loss, and to return mail-order policies within 30 days.

Fourth, such policies must provide full disclosure of the provisions contained within the contents of the insurance plan.

Finally, policies must be expected to return to policyholders, in the form of aggregate benefits, at least 75 percent of the amount of premiums collected, in the case of group policies, and at least 60 percent, in the case of individual policies.

The minimum loss ratio requirement is a key standard in the voluntary certification program. Congress intends this requirement to ensure that policyholders receive reasonable financial return for their health insurance dollar.

In the area of Medicare supplementary insurance, it is common practice for some companies to return as little as 20 or 30 percent on the premium dollar. The average loss ratio for all health insurance within the insurance industry is 80 percent. We believed it unconscionable to let companies return only 20 or 30 cents on the premium dollar, retaining the rest in profits and administrative expenses.

The voluntary certification program will not be applicable in any State which has enacted and implemented standards equal to or more stringent than the Federal Medigap standards. A newly established Supplemental Health Insurance Panel will determine whether a State's regulatory program meets these standards. Appointed by the President, the panel will consist of four insurance commissioners and the Secretary of HHS. By January 1, 1982, this panel will prepare and submit a report to the Secretary identifying those States that do not qualify for exemption under the

Medigap statute. The Federal program will apply, effective July 1, 1982, to those States identified by the panel as not having adequate Medigap programs. The law also requires a new emblem to be used to help consumers identify Medicare supplemental policies that meet minimum standards with respect to coverage and benefits.

The Act also establishes Federal penalties for engaging in certain fraudulent or abusive activities. Penalties would be provided for furnishing false and misleading information for the purpose of obtaining certification; for misrepresentation as an agent of the Federal government for the purpose of selling insurance to supplement Medicare; for knowingly selling insurance policies whose benefits would be reduced or denied because they duplicate benefits under another policy held by the purchaser; and for knowingly advertising, soliciting, or offering mail order policies in a State, contrary to the desire of the State insurance commissioners. Anyone convicted of engaging in such fraudulent or abusive practices, would be subject to a fine of up to $25,000 and imprisonment for up to five years.

No longer will health insurance policies just come in the mail. If the State insurance commissioner specifically disapproves the policy, anyone selling those Medigap policies by mail would be commiting a felony. This provision was enacted to assure that a State regulator has Federal sanctions available to help protect the residents of the State from mail order policies not now covered by State regulatory power. Several procedures provided by the Act eliminate the need for special review of policies approved for both inter- and intra-State use.

Under P.L. 96-265, the Secretary of HHS is required to conduct several studies and, every two years, to report to Congress on the effectiveness of the voluntary certification program. The Secretary also will assess the effectiveness of criminal penalties established by the Act.

In addition, the Secretary will consult with regulatory agencies, insurers and consumers and will determine how effectively States are regulating Medicare supplemental policies. Under the law, individual States are provided the opportunity to suggest improvements for the Federal program.

The Federal Medigap program will be limited to those States not establishing equivalent programs of their own. This represents Congress' effort to encourage each State to work out its own solutions to the Medigap problem; thus, the effective date of the certification procedure has been set at July 1982 to allow States time to enact and implement regulatory programs.

Conclusions

The Federal voluntary certification program represents one solution to the abuses and confusions in the Medigap field, and one that Congress feels fully justified in taking, since the problems have arisen around the Federal Medicare program and its beneficiaries.

This legislation, we believe, will foster a more cooperative effort among legislators, regulators, and the regulated, to control abuses in the Medicare supplementary health insurance field. In this spirit of shared responsibility, we believe we can provide assurance to older Americans that adequate health insuance protection to supplement their Medicare coverage is available. By enacting this legislation, Congress has confirmed its commitment to protecting senior citizens by making Medigap problems a thing of the past.

Senator Max Baucus (D-Montana) serves on the Senate Finance Committee, which is responsible for Medicare and Medicaid legislation. A graduate of Stanford with a B.A. in economics, he also received an LL.B. from Stanford Law School. Prior to his election to the Senate, he served two terms in the U.S. House of Representatives.

NOTES:

1. Baucus, Max (Sen.) Voluntary Certification of Medicare: Supplemental Health Insurance Policies Congressional Record. v. 126, January 30, 1980: S 633-642.
2. U.S. Congress. House. Select Committee on the Aging. Abuses in the Sale of Health Insurance to the Elderly. Hearings, 95th Congress, 2nd session. Washington: U.S. Government Printing Office, 1979. 366 pgs.
3. U.S. Congress. House. Select Committee on the Aging. Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal. Staff study, 95th Congress, 2nd session, Washington: U.S. Government Printing Office, 1979. 444 pgs.
4. De Novo, Anne and Shearer, Gail. *Policy Planning Issues Paper: Private Insurance to Supplement Medicare.* 2 vols. Washington, D.C., Federal Trade Commission, July 1978.
5. Van Ellet, T. *Medigap: States Responses to Problems with Health Insurance for the Elderly.* Washington, D.C.: Intergovernmental Health Policy Project, The George Washington University, October 30, 1979.

MEDICARE AND PRIVATE SUPPLEMENTARY INSURANCE

by WOODROW E. ENO, J.D.

Although the Medicare program offers health insurance protection to senior citizens, they continue to purchase private health insurance policies to supplement their Medicare coverage. There are at least two reasons for this. First, the Medicare law designed by Congress does have coverage limits and Congress has not appreciably expanded the coverage since the program's enactment in 1965. Along with the initial deductibles and coinsurance amounts, some of the other health expenses Medicare does not cover include routine physical examinations, routine dental treatment, and immunizations. In developing any public program certain events (i.e. inflation) or the full extent of the needs of the covered group cannot be foretold accurately. Second, senior citizens are typically captives of fixed income and, hence, feel a strong need to protect themselves from the fact of life that the older one gets, the more likely one is to encounter large health care expenses.

The relationship of private health insurance to Medicare has been questioned since the advent of Medicare. When the Medicare bill was under consideration in June of 1965, the insurance industry's expectation for the future was rather bleak. In commenting about the then proposed Medicare program, offering both hospital and optional medical coverages, an industry spokesperson suggested that "there will be little, if any, room left for private health insurance for those 65, and coverage now in force would be eliminated."[1] Another speaker, reflecting on the impact of the proposed Federal law on the private insurance marketplace, concluded that "if we (insurance carriers) avoid duplication, the benefits left for us to provide are so small that it will not be efficient to try and sell individual policies to this market."[2]

Today, results have been the opposite. There is clearly a market for Medicare supplemental policies. According to statistics available at the end of 1977, some 12.6 million people over age 65 had private health insurance to supplement Medicare.[3] It is interesting to note also that today approximately 60% of those over 65 have private health insurance,[4] a figure almost identical to the percentage of senior citizens with private coverage in 1965[5] when these forecasts were made by the insurance industry.

Some allegations or instances of possible abuses in sales activities and/or policy coverage of Medicare supplemental policies have been discovered and publicized over the past several years. This article will briefly discuss what the private insurance industry and State governments have done in an attempt to resolve these problems.

Several instances of improper sales activities which were uncovered were presented to the public and the government. One atypical but spectacular example concerns an 80-year-old woman who reportedly spent more than $50,000 in three years paying premiums on numerous insurance policies, among which were 31 policies to supplement her Medicare coverage. She ended up taking a loan to help pay her premiums. This is one extreme example of a senior citizen spending a large percentage of his or her limited income on several policies, without understanding their coverage or analyzing the impact of the premiums on their budget.

A number of State insurance departments began to respond to the abuses they observed in the marketing of inadequate and duplicative health insurance to senior citizens. In addition, in May, 1978, Congress began investigative hearings concerning unprofessional and improper sales practices and is considering several bills.[6] As more information became available to Congress, besides the information concerning the sales tactics, it appeared that there might be problems concerning the policies that were being offered to senior citizens.

These hearings and other publicity revealed instances of some serious abuses in the marketing of health insurance to senior citizens. Even though the majority of coverage and sales are carried out in a responsible and professional manner, it was decided by the industry itself that

some broad reaching and active measures needed to be taken. Prior to formal action by legislators or regulators, the industry formed its own task force to pursue some alternatives that could be used to identify the problems, and to try to offer some solutions so that retired people could better understand their Medicare and private coverage, and could make wiser decisions when buying policies to supplement Medicare.

The Health Insurance Association of America (HIAA), as the trade association for private insurance companies, offered its assistance to all State insurance regulators.[7] Correspondence was directed from the HIAA to the chief officer of each member company encouraging a kind of "peer pressure" examination of policies and sales tactics.[8] The Health Insurance Institute, the public relations arm of the private health insurance industry, located at 1850 K Street, N.W., Washington, D.C. 20006, also prepared a consumer education booklet, *"What You Should Know About Health Insurance When You Retire,"* approximately 400,000 of which have been given out free of charge.

A Joint Effort—NAIC Model

State insurance regulators felt the need to exchange concerns about these problems, so they used their national forum for this purpose. The National Association of Insurance Commissioners (NAIC), a voluntary association of the chief insurance regulatory officials of the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands, appointed a special group of State insurance commissioners under the leadership of the Wisconsin Insurance Commissioner to search for solutions to the problems of oversale or inadequate policies.

To assist in this project, the NAIC Task Force on Medicare Supplement and Limited Insurance appointed a special Advisory Committee, unique in its make-up. It became a joint Federal-State and industry-consumer effort, including representatives of the Department of Health, Education, and Welfare (HEW),* the Federal Trade Commission (FTC), consumer groups, senior citizens groups, and the insurance industry.[9]

Although it could not be determined that the problem was widespread, based on the evidence we could obtain,[10] when viewed against the size of the population involved, the number of complaints is low. However, it was recognized that some serious incidents had occurred that could not be condoned. Despite the size of the task and the fact that those working on it under the umbrella of the NAIC were volunteers with other full-time responsibilities, it was felt that any new legislative or regulatory proposals should be prepared and ready for adoption in less than six months. The NAIC established a deadline of June 6, 1979, for its task force.

NAIC Model Act

One of the first steps taken by the NAIC Task Force and its Advisory Committee was to decide whether to create additional legislation and regulation, or to build some stricter controls over these policies into existing legislation and regulation. The task force decided that the NAIC Model Individual Accident and Sickness Insurance Minimum Standards Act provided the best starting point. Developed in the 1970's and first adopted by the NAIC in 1973,[11] the purpose of the Act is to provide reasonable standardization and simplification of terms and coverage of individual health insurance policies. In addition to facilitating full disclosure for individual policies, the Act authorizes the State's insurance regulator to adapt minimum standards for benefits.

Although the Act was originally intended to include all individual health insurance policies, no indepth handling regarding Medicare supplemental policies had ever been accomplished. Apparently, the original Model Act was developed before this particular problem manifested itself. In amending the Act to specifically address this problem, the first step was to create a special category of coverage for "Medicare supplemental policies."

A section was also placed in the Act that would give State insurance commissioners expanded authority to withdraw approval or suspend further sales of such policies, if the benefits provided in them are unreasonable in relation to the premium charge. This provides for continuation of loss ratio[12] monitoring while the policy is in force.

The Act, as amended for Medicare supplemental policies, also provides that an outline of the coverage under the policy be provided to the prospective insured with the application. The final adaptation was to authorize that the State

*Now the Department of Health and Human Services

insurance commissioner may require a buyer's guide to be provided to the person to be covered by a Medicare supplemental policy.

NAIC Model Regulation

This completed the task force's proposals for legislation;[13] however, changes regarding Medicare supplemental policies still had to be made in the NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act.[14] This would give those States adopting these model proposals special regulatory controls tailored toward these policies.

The NAIC Medicare Supplemental Advisory Committee recommended that the implementing regulation should be used to eliminate some of the confusion over what is actually a "Medicare supplemental policy." To accomplish this, a prohibition was placed upon using the terms "Medicare supplement," "Medigap," and words of similar import, unless the policy actually qualifies within the minimum benefits set out in the regulation. The prohibition not only applies to the policy, but also to advertising, marketing, or other usage.

Generally speaking, the regulation provides that coverage shall not be subject to exclusions, limitations, or reductions which are inconsistent with those permissible under Medicare. There are some exceptions to the general statement. Most notable, a preexisting condition limitation is allowed in the regulation. This limitation shall not, however, exclude coverage for more than six months after the policy's effective date for a condition for which medical advice was given, treatment recommended by, or received from, a physician within six months before the effective date of the policy. The rationale behind this was that a preexisting condition could be allowed to prevent coverage, but for a reasonably short period. After this period, the coverage should begin even for those diseases or illnesses that existed when the policy was purchased. This should eliminate the carrier's ability to "rider-out," or specifically exclude diseases or illnesses the person had previously.

The NAIC Model Regulation specifies the following minimum benefits, all of which must be provided in order for a policy to be approved as a "Medicare Supplement." The regulation emphasizes that these are purely *minimum* standards, and that insurance companies are not precluded from the inclusion of higher levels of coverage or additional benefits:

(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(b) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days, to the extent not covered by Medicare;

(c) Upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days; and

(d) Coverage of 20% of the amount of Medicare eligible expenses under Part B, regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 and a maximum benefit of $5,000 per calendar year.

It should be noted that the dollars and percentages expressed above are set as a starting point for those States who may wish to adopt the regulation and are intended to be used in establishing what minimum should be set. States, of course, can vary them according to local needs and costs.

These benefits obviously do not require the coverage of the Part B deductible and the initial expense of Part A. It was the consensus of the NAIC Task Force and its Advisory Committee that these should not be mandatory requirements for a minimum benefits policy. The members also felt it permissible to allow these as cost sharing deterrents to overutilization. In pricing out the prototype Medicare supplemental policy, it becomes apparent that a certain amount of dollar trading is involved. In simplistic terms, this means that older people are more likely to have medical and hospital expenses than younger people. In order, therefore, to cover the initial expense of this high risk population, an insurer must charge (or trade) almost the same amount in premium as in coverage. Some private insurance companies offered this coverage prior to NAIC's recommendation, as did many Blue Cross - Blue Shield plans. Insurance companies themselves are

anticipating wide adoption of the NAIC Model Regulation and some are already redesigning their policies along its lines.

As stated, these minimum benefits link the reimbursement for medical expense to "the amount of Medicare eligible expenses." A number of analysts have commented on the difference between Medicare's reimbursement level under Part B as "reasonable," compared to a physician's actual fee.[16] The difference in reimbursement levels that this creates seems to be an increasing problem, since the percentage of physicians accepting assignments is only about 50% and is declining.[17]

There was considerable sentiment within the NAIC and its Advisory Committee to require that the minimum benefit levels for Part B Supplementation be somewhere above Medicare's determination of "reasonable." Because of the possible undesirable inflationary effect, and the concern that this would only lessen the number of physicians that will accept assignments, the NAIC Model Regulation does not require anything above Medicare's "reasonable" Part B reimbursement. It was reasoned that to do otherwise would encourage the physician to rely upon supplemental coverage for collecting additional fee amounts and, hence, even lessen the number accepting assignment of Medicare claims.

The impact of the difference between Medicare "reasonable" reimbursement and the actual charge in terms of dollar drain on the elderly cannot, however, be overlooked. The NAIC Task Force and Advisory Committee felt that HEW and the Congress may wish to explore this issue beyond the smaller one of private supplemental insurance coverage.[18]

Some private insurance companies and some Blue Cross - Blue Shield plans currently cover their own (higher) definition of "reasonable" and reimburse at this level, regardless of Medicare's determination. This is done in part to obtain a competitive edge, but also to provide the senior citizen coverage of the exclusions in Medicare. This coverage can be of great benefit since the Medicare program covers only 38% of the senior citizen's total health care costs.[19]

The two final requirements added to the NAIC Model Regulation are both aimed at providing senior citizens simplified information concerning the benefits of the Medicare program. The goal is to explain the coverage of private supplemental insurance and its relationship to the program being supplemented. One measure suggested is the Outline of Coverage. This document is to be provided the applicant prior to the sale of a Medicare supplemental policy and lists the Medicare benefits and its exclusions, what the policy covers, and what is left for the senior citizen to pay.

Additionally significant is that sales of hospital confinement indemnity (fixed daily inhospital only payments), specified disease (covering only expenses for cancer, heart attack, etc.), or other limited health insurance coverage to Medicare eligibles are addressed in the NAIC Model Regulation. The regulation requires that a prominent warning be placed on the outline of coverage for these limited policies that such a "Policy is Not A Medicare Supplement policy."

In addition to requiring the Outline of Coverage, the NAIC Model Regulation would also require that the senior consumer be provided with a copy of a buyer's guide, developed jointly by the Health Care Financing Administration (HCFA) and NAIC. The *Guide to Health Insurance for People with Medicare*, a basic informational pamphlet, provides more consumer information than the brief policy description in the Outline of Coverage. It explains what Medicare does and does not cover, describes the kinds of private insurance supplements available, and provides useful information to beneficiaries considering the purchase of supplemental insurance. The buyer's guide is available free from State insurance departments, Social Security and HCFA offices and from many senior citizen centers. The consumer demand for this guide probably speaks for its value. Currently three million copies have been requested with dispersal planned for an additional six million copies now being printed.*

One final feature of the NAIC Model Regulation is important since it interlocks with all the other provisions. The Model Act and Regulation, even prior to amendment, provided for a free chance to examine the policy. This means that a purchaser may return the policy within a specified time period and receive a full refund. The Medicare supplement amendments to the NAIC Model Regulation expanded this time limit. For such policies bought through the mail the period was expanded to 30 days, and left

*The additional pamphlets are now being distributed. Ed.

at 10 days for policies purchased from agents. The 30 days allows those purchasing through the mail longer to get the buyer's guide in order to make an informed decision.

State Implementation

The Medicare supplemental insurance changes to the Model Regulation were adopted by NAIC in June, 1979. Prior to this activity, a number of States had taken their own measures, either through regulation or legislation. Since June 1979, a number of other States have adopted some form of the NAIC Model or are in the process. The chart at the end of this article shows these activities as of January 21, 1980. A synopsis of proposed legislation for these 33 States is not included since this involves guesswork about enactment. Laws or regulations now in effect or actually in the stage of implementation are included.

We believe it is a safe assumption that the NAIC Model will be accepted in the various States because the Model Act and Regulation and its accompanying buyer's guide are the products of a joint effort between the national trade association for private insurance regulators, two Federal agencies, senior citizens groups, the trade organization for private life insurance agents, and numerous insurance industry personnel. The adoption of these items is also supported by the health insurance industry and its trade association, HIAA. Once the proposed measures listed above are added to the existing measures dealing specifically with Medicare supplemental policies, the percentage of the Medicare population residing in States having specific laws or regulations will be more than 75%.

Listed below are some of the enforcement tools currently available to the States. These requirements were often enacted with industry assistance and encouragement:

1. Prior approval of all policies by State insurance departments. Currently, all States require approval or filing. This law also includes a minimum 10-point type size requirement.
2. Fair trade practice laws which define unfair actions in most aspects of insurance, including sales, underwriting, and claims.
3. Agent training and licensing requirements.
4. Detailed regulations governing truth in advertising.
5. Prohibitions on misleading or deceptive replacement of policies (called "twisting").
6. Policy language simplification requirements.
7. An Unauthorized Insurance Service of Process Act, which allows policyholders to sue out-of-State companies in the State of residence and to subject such an out-of-State company to that State's jurisdiction.

The NAIC Model Act and Regulation does not represent all the solutions. However, adapting these to a State's regulation is intended to harmonize and increase the effectiveness of controls, and to assure senior citizens of broad coverage at a reasonable price. These NAIC Model Laws also provide senior citizens with extensive consumer information so that they can, like any other citizens, make informed and intelligent decisions in today's health insurance market. Given a good foundation of information and a number of policies to pick from, their interest should be keen enough to assure a beneficial effect.

Woodrow E. Eno, Counsel for the Health Insurance Association of America, is a graduate of the University of Nebraska College of Law, and received a B.A. from Pittsburg State University. Mr. Eno currently deals with State legislation and has served as a staff representative to various National Association of Insurance Commissioners' committees. Mr. Eno previously served as an attorney with the Judge Advocate General's Corp., U.S. Army.

NOTES:

1. *II Proceedings of N.A.I.C. 1965*, p. 333.
2. Ibid, p. 335.
3. Health Insurance Institute, *Source Book of Health Insurance Data*, 1976-77, p. 21.
4. Health Insurance Institute, *Source Book of Health Insurance Data*, 1978-1979, p. 7.
5. *II Proceedings of N.A.I.C. 1965*, p. 335.
6. H.R. 165 (Brodhead & Evans), 96th Congress, 1st Session: H.R. 2602 (Pepper & Scheuer), 96th Congress, 1st Session: S. 395 (Chiles), 96th Congress, 1st Session: H.R. 3236 (Baucus Amendment to the 1979 Social Security Disability Amendments), 96th Congress, 2nd Session: and H.R. 4000 (As reported by the House Ways and Means Committee) 96th Congress, 2nd Session.
7. Letter from Robert F. Froehlke, President, HIAA, to all State insurance commissioners, February 2, 1979.
8. Letter from Robert F. Froehike, President, HIAA, to the Chief Executive Officer of each member company, March 30, 1979.

9. Listing of the Advisory Committee to the NAIC Task Force on Medicare Supplement Insurance:

   Mr. Gerald Parker, The Guardian Life Insurance Company of America; Mr. Arnold J. Rossoff, HEW, Health Care Financing Administration; Mr. Richard Cooley, The Travelers Insurance Company; Mr. Arthur Becker, Colonial Penn Group; Mr. Donald Lowry, CNA Insurance; Mr. Calvin Wheeler, Mutual of Omaha Insurance Company; Mr. George Heitler, Blue Cross/Blue Shield Association; Ms. Judy Feder, The Urban Institute; Ms. Karen Jones and Ms. Sally Hart Wilson, National Senior Citizens Law Center; Mr. Maury Kiley, National Association of Life Underwriters; Ms. Ann DeNovo, Federal Trade Commission; Mr. Thomas R. Hefty, Chairman, Sentry Insurance; Woodrow Eno, Staff, Health Insurance Association of America.
10. (a) Letter from Albert B. Lewis, New York Superintendent of Insurance, to the HIAA, February 22, 1979, ("They (my staff) advise me that there is no indication that such a problem exists in New York as the media indicates may be happening in other States."); (b) Letter from George D. McDonald, Florida Chief of Life and Health Insurance, to the HIAA, February 14, 1979; (c) Letter from Joseph S. Flowers, Delaware Director of Health Insurance, to the HIAA ("...we conducted our own State investigation of the sale of such insurance and have concluded that few problems exist, and that those problems which do exist have been brought under control.")
11. *I Proceedings of N.A.I.C. 1974*, pp. 414-418.
12. The subject of "loss ratio" is so complex that it offers the opportunity for indepth study on its own. There is a general lack of understanding of "loss ratio" not only by the general public, but among both the insurance industry and its regulators. The term "loss ratio" has many valid meanings. It can be a valuable tool in examining the relative value of a health insurance policy, but the method of calculation plays a greater part in the result than do the actual numbers used in any given formula. Using the same figures, results can vary by 200%. While loss ratios are valuable to technical people, the type generally seen by the public are less than conclusive evidence. Even within actuarial circles, loss ratios are used as mere indications of other factors. There are many factors of equal or greater importance in judging the relative value of a health insurance policy. Such items as speed in the payment of claims, solvency of the insurer and the term of renewability of the policy are just a few.
13. Adopted by the N.A.I.C. December 8, 1978, *I Proceedings of N.A.I.C. 1979*, pp. 394-396.
14. Adopted by the N.A.I.C., June 6, 1979, *II Proceedings of N.A.I.C. 1979*, (not yet published).
15. *Private Health Insurance to Supplement Medicare*, a Policy Planning Issues Paper of the Federal Trade Commission, July, 1978, p. 11.
16. Ibid, and *Private Health Insurance for the Elderly: Filling Medicare's Gaps*, a working paper by Judith Feder, The Urban Institute, Washington, D.C.
17. HEW, HCFA, *Part B Carrier Workload Report*, October 1977. This report also shows a tremendous variation by region in the percent of claims assigned (24.6% in Wyoming to 70% in some industrial States).
18. *Report of the Advisory Committee to the N.A.I.C. Task Force on Medicare Supplement Insurance*, June 3, 1979.
19. Op Cit, *Private Health Insurance to Supplement Medicare* (Federal Trade Commission).

STATE ACTIVITIES DIRECTED SPECIFICALLY
at
MEDICARE SUPPLEMENTAL POLICIES
(A Synopsis as of May 21, 1980)

Arizona	Hearing held on proposed regulation concerning agents' disclosure practices. Final Regulation pending.
California	Regulations adopted setting loss ratio, minimum benefits, and disclosure requirement.
Colorado	1976 regulation adopted dealing with the replacement of Medicare Supplemental Policies. Two laws passed in 1978, one requiring disclosure in simplified terms, and the other setting a loss ratio. Implementing regulations also adopted in 1978.
Connecticut	Law passed stating deceptive acts and granting Commissioner of Insurance broad regulatory authority.
Delaware	Insurance Department survey of policies designed primarily for filling exclusions coinsurance.
Florida	Final Regulation adopted (effective July 1, 1979) providing rules for solicitation.
Illinois	1978 law passed setting minimum benefits and policy requirements. Department of Insurance handing out buyer's guide.
Idaho	Proposed regulation pending final adoption.
Iowa	Law passed concerning nursing home policies. Proposed regulation is pending final adoption.
Kansas	Commissioner used existing authority to deal with fraud and held extensive agents hearings resulting in a number of sanctions. Booklet provided by the Insurance Department.
Maryland	New law effective July 1, 1979.
Massachusetts	Regulation adopted that sets loss ratio, minimum benefits, and language simplification requirements.
Michigan	Law passed requiring all companies to offer a comprehensive policy at a specified loss ratio.
Minnesota	Law passed requiring the offering of a qualified Medicare Supplemental plan and a regulation setting a loss ratio.
Montana	Regulation adopted setting disclosure requirements.

STATE ACTIVITIES—Continued

Nebraska	Legislature enacted requirement that the State Insurance Department adopt strict regulations implementing the NAIC standards.
New Jersey	Use of existing authority to conduct extensive investigations of agents and companies. Booklet developed and provided by Consumer Division. Regulation pending.
New Mexico	Regulation adopted requiring comprehensive disclosure of the relation between the policy and Medicare.
New York	Regulation adopted extending benefits for Medicare supplemental policies to include home health care.
North Carolina	Regulation pending final adoption.
North Dakota	Survey by Insurance Department of policies marketed to the elderly.
Ohio	Regulation adopted specifying disclosure requirements. Regulation pending concerning standards and agents.
Oregon	Regulation adopted specifying disclosure requirements. Law enacted specifying loss ratio and minimum standards.
Pennsylvania	Regulation adopted defining Medicare supplemental policies and requiring explanation of items covered.
South Carolina	Final regulation adopted implementing the NAIC standards effective July 1981.
South Dakota	Final regulation adopted setting disclosure requirements.
Tennessee	Booklet distributed by Insurance Department. Legislation being drafted for next session.
Texas	Regulation adopted for minimum standards, specifies content of a minimum benefit, Medicare supplemental policy and disclosure requirements.
Utah	Law passed for minimum benefits sets specifics for Medicare supplemental policies, including preexisting conditions limiations. Implementing regulations adopted.
Vermont	Regulation adopted effective June 1980, implementing the NAIC standard.
Washington	Regulation adopted setting disclosure requirements.
Wisconsin	Regulation adopted setting standard categories of benefit levels and policy terms. Disclosure required under separate regulation.
Wyoming	Extensive investigation of company and agent practices under existing authority. Proposed regulation pending final adoption.

A HCFA INITIATIVE: SAVINGS THROUGH ZIP SORTING MAIL

by BARBARA T. DANIELS

Introduction

In this time of limited fiscal resources, public agencies are focusing more intently on good management, seeking ways to better utilize finite funds and staff. In Medicaid, for instance, these efforts may be as ambitious as installing an automated claims processing system with subsystems for utilization review or third party benefit recovery. There are other operations that lend themselves to appreciable savings, yet are so much a part of routine procedures that they may be overlooked. One such operation is that of mail handling, particularly in the context of the Medicare and Medicaid programs, where extensive mailings occur daily.

This article describes the system planning and implementation of a postage discount in HCFA's Medicare program. Medicare alone posts some 150 million first class pieces of mail yearly; Medicaid mail volumes are similar in magnitude. Considering this volume, HCFA projects an annual savings for its programs at $2 million in net administrative cost reduction.

Background

In early 1976, the U.S. Postal Service announced a one-cent postage discount for first class mail that was presorted by zip code. HCFA's Bureau of Program Operations staff realized that this was an opportunity for significant postage cost avoidance for Part B Medicare claims (physician and related services). Postage costs associated with Part A Medicare claims (hospital services) are minimal because intermediaries make direct payments to relatively few institutions. However, Part B carriers pay more than 120 million claims per year, mailing checks and explanations of benefits directly to Medicare beneficiaries and their physicians and suppliers. Advantages of a presort system would include not only discounted postage, but also improved service — in most cases presorted mail travels faster and more directly to dispatch.

Pilot Presort Program

To test the presort method in a claims processing environment, the Bureau's Office of Methods and Systems (OMS) initiated a presort pilot program with a Part B carrier in June 1976. At the onset, the presort program was new to the Postal Service as well as to HCFA. The cost benefit of such a system was obviously dependent upon mail mix and volume. OMS selected Pennsylvania Blue Shield to operate the pilot project for two reasons. Pennsylvania Blue Shield had their own zip sort software in place, thus the pilot would require minimal startup costs. Also, in generating about 30,000 pieces of mail per day, this carrier represents one of the largest Part B carriers.

Pennsylvania Blue Shield set up their presort system as soon as the discount was offered. With no precedents to guide them, this carrier proceeded to learn the intricacies of postal regulations, and to establish a working interface with the Camp Hill Post Office. The regulations specifying minimum sizes for bundles with all five digits matching and with first three digits matching are the most important requirements of the presort process.

Pilot Results

One of the lessons we learned from the pilot study was the importance of print run lengths and mail mix to a successful zip sort on computer main frame. The relatively short print run sequences inherent to Medicare Part B claims processing can pose a major stumbling block to profitable sorting. Clearly, in a Part B claims processing environment, some alternative to sorting on main computers would be necessary to reach a national qualification rate that would make sorting worthwhile. (The qualification rate is that percentage of mail which meets Postal Service requirements for the discount. The remainder is considered residue and must carry full postage.) We needed a viable method for

converting all of the zip codes from a variety of computer print runs into one long zip code stream. Short code streams simply resulted in too much residue, given a mail mix that contained all of the zip codes for an area as large as the Commonwealth of Pennsylvania.

In 1978, when it became apparent that the presort discount would be raised to 2 cents for each letter, the business equipment industry developed off-line and end-of-line hardware for sorting finished pieces of mail generated throughout a large organization — sorting that would effectively turn all of the mail into a long string of zip codes. To accomplish this, some of the machines were designed to use OCR (optical character recognition) scanners which read the zip codes and sort the mail according to a scheme worked out for a particular mail mix. Other machines use multiplexed keyboards and abbreviated keying schemes, e.g., two or three digits of the zip code. The result of such systems was that the qualification rate would increase from 60 percent on selected individual computer runs to about 85 or 95 percent on all runs combined. Thus, manual handling would be minimized.

Cost benefit analyses of the new equipment indicated that for small scale hardware (220,000 pieces of mail per month) or large scale hardware (550,000 pieces of mail per month), installation costs versus savings could break even in less than two years. Also, this class of machinery would require no systems modifications except, perhaps, for new print trains for the OCRs. The machinery could handle all of the mail generated by Medicare, Medicaid or underwritten business, to achieve the long stream of zip codes and resulting high qualification rate. During the next several months, further testing by OMS staff confirmed that the hardware designs were debugged and reliable. It was now obvious to OMS that all but one or two of the smallest Part B carriers could profit by using the hardware.

Marketing The Zip Sort Discount

After the competitive market had grown, OMS identified four viable companies with operational installations at the National Postal Forum in September 1978. Soon after, in an effort to promote HCFA's interest in the discount, and to present a variety of alternative sorting techniques for contractors, OMS set up workshops for the contracting community.

The Kansas City Regional Office responded to HCFA's request to host the pilot workshop, with support from the Postal Service. This was a tri-regional meeting with Chicago and Dallas also participating. Although the workshop was clearly a central office initiative, regional offices selected the contractors to be represented, based on breakeven data supplied by OMS. Regional offices also issued the invitations, turned in advance registration lists to OMS, and determined appropriate regional office representation.

The format worked out in Kansas City involved a tight one day schedule of speakers and discussions. Opening remarks by a Medicare executive were followed by Postal Service speakers, who outlined the ground rules for the presort program. Four hardware vendors were then given thirty minutes each to describe their companies and products. Speakers who had used the equipment concluded the session, putting the entire day's proceedings into focus for the participants.

Workshop speakers shared their experiences generously; they were frank about problems they had encountered and the steps necessary to solve those problems. Evaluations of the workshop showed positive reaction from participating regional offices and contractor representatives. Then, San Francisco offered to host the next workshop.

The format described above remained the same for all three workshops; speakers changed in the various locations. In the West, we were unable to find any Medicare contractors with presort experience.

Therefore, three companies from the private sector — Prudential Insurance Company's Western Home Office, Wells Fargo and General Telephone of California — sent one speaker each, at no cost to the government. In fact, the only expense for the workshop series was government staff and travel time, and that was modest.

Projected Savings and Advantages

HCFA projects a net annual savings of about $1 million to the Part B Medicare program. This projection is based on the maximum discount obtainable from 150 million pieces of mail, assuming a sorting cost of 0.75 cent per piece, or a total of $1,875,000. This figure has been rounded down to $1 million since we expect an average 85 percent qualification rate, and less than 100%

participation in the program. In addition, the 0.75 cent sorting cost is a conservative estimate. The Pennsylvania Blue Shield pilot project used main frame sorting with an entirely manual process for detecting zip breaks, counting pieces per 5-digit and 3-digit bundle, and applying markers; the sorting cost was 0.5 cent per piece of mail.

As stated earlier, Part A Medicare mail volumes are generally too low for profitable zip sorting for discount, (unless the contractor is in a position to merge Part A mail with organization mail volume, i.e., Part A plus underwritten or other contract business). In the Medicaid program, it is reasonable to assume that the opportunity to lower postage costs *equals or exceeds* that in Part B Medicare. Although Medicaid's checks are written less frequently, claim volume is much higher and a wider range of provider types are involved. (Pharmacies, for example, have no contact with Part B Medicare but are providers under Medicaid.) In addition, Medicaid mail lends itself well to sorting on main frame since print runs tend to be less frequent, less fragmented, and longer than in Part B Medicare.

HCFA is quite comfortable in projecting a $2 to $3 million annual cost avoidance from first class postage discounts.

Some organizations have also reported an intangible benefit: planning for the program focuses attention on the mail room, a critical but often neglected component of a claims processing organization. These organizations also learned a great deal about computer address files and the mail stream within their environs; general improvements in other operations have resulted as well.

Conclusion

In September 1979 and again in January 1980, we conducted an informal survey of regional offices to determine Medicare participation in the zip presort program. As of January, 20 Medicare carriers had established such programs. We did not inventory State agencies; however, one region reports 100% participation. Based on these findings, we expect HCFA's annual system cost avoidance to reach the projected $2 to $3 million during the next year.

For further information contact the author in HCFA, Bureau of Program Operations, Office of Methods and Systems, 519 East High Rise, Baltimore, MD 21235.

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A CASE FOR FIRE SAFETY REGULATIONS

by JANICE CALDWELL, Dr. P.H.

Preventive action is a concept many value in principle but often fail to perform. In our personal lives, we often put off preventive maintenance for our homes or cars, and sometimes regret this procrastination. Regulations that require yearly auto inspection, for example, are designed to "help" us practice prevention and we admit it, but grudgingly.

Federal fire safety regulations for Medicare and Medicaid certified nursing homes, which have been in effect since 1971, require many preventive measures. These regulations not only address the soundness of the physical structure, but also staff behavior, to assure they are prepared for the possibility of a fire or a disaster. Federal nursing home regulations require, among other things, that emergency procedures and evacuation plans be posted, familiar to employees and displayed prominently in several often frequented locations, and that staff training include monthly rehearsals of fire drills and evacuation routines. The required disaster drills are designed to serve several purposes:

1. To ensure that new employees are trained as soon as possible;
2. To establish a routine to such drills so that employees will perform their responsibilities automatically; and
3. To preoccupy employees with performing established duties to forestall panic an emergency can induce.

This article discusses such staff training, how the training was successfully put to the test during a nursing home fire, how a locality handled the fire, and the results of a fire department investigation of the fire.

The Unexpected Happens

At approximately 8:30 a.m. on April 13, 1979, a smoke detector sounded on one of the two wings on the second floor of the two-story University Nursing Home, Silver Spring, Maryland. The home was certified as meeting Medicare and Medicaid physical plant requirements. A flow of convected heat and dark smoke coming from room 27 in B wing, had activated a smoke detector in a lounge approximately 15 feet away. The activation of this smoke detector automatically set off the home's internal alarm system. The facility receptionist, hearing the alarm, immediately dialed 911 and notified the Montgomery County Emergency Operations Center.

The facility staff responded, closing the doors to all the patient rooms in the B wing, with the exception of room 27. Room 27 flashed with heat and smoke, forcing the staff out of the area. The smoke barrier doors (required under Medicare and Medicaid regulations) closed when the local alarm system went off and prevented the smoke from spreading to the A wing. (See Diagram I.)

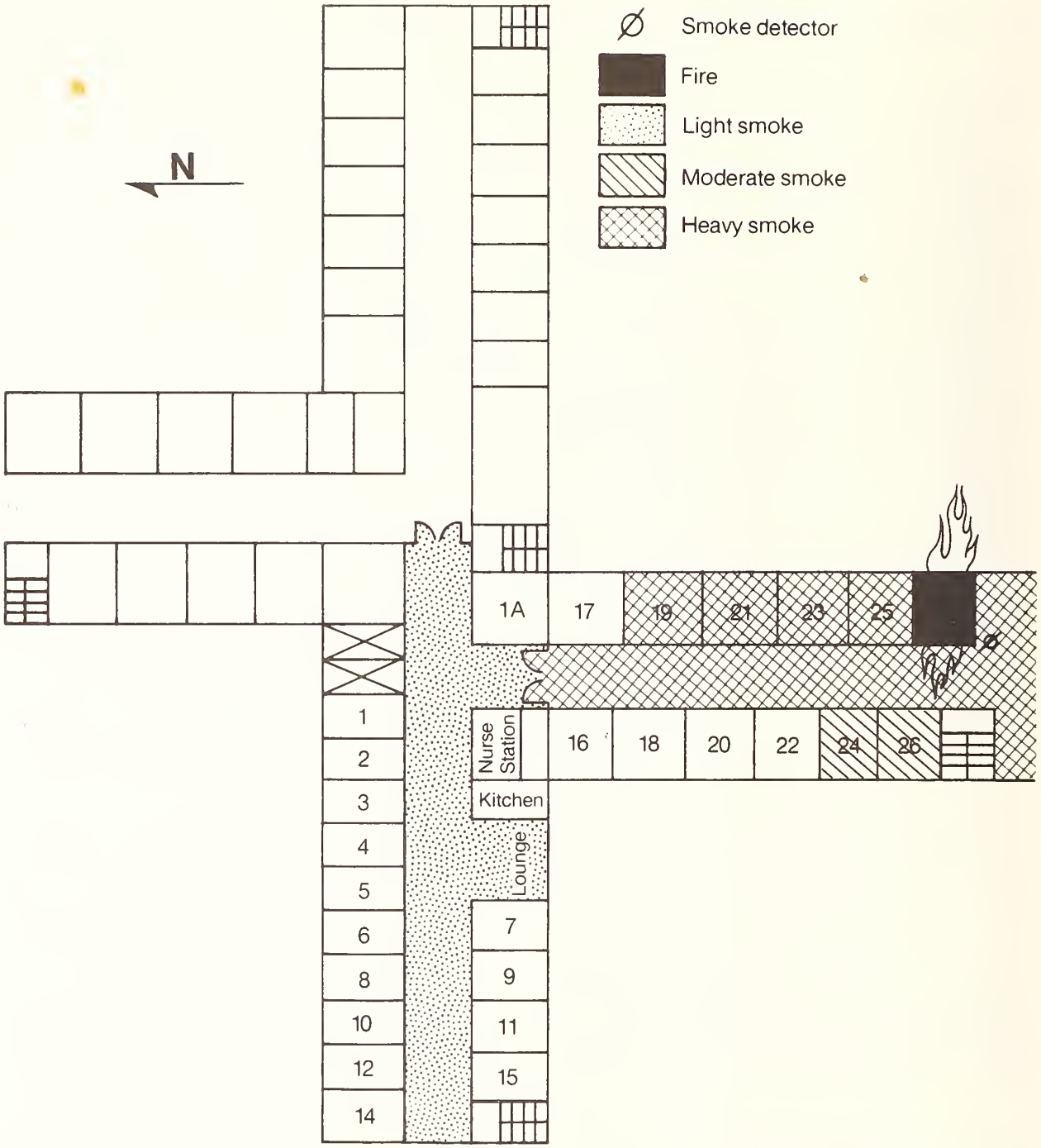
The first fire fighters to arrive attacked the fire through the window of room 27. Twenty-one patients were removed from rooms 16 to 26 in A wing, seven of these down ladders. An additional 26 patients were evacuated from B wing. Seventeen patients and eight staff members were taken to nearby hospitals for treatment for smoke inhalation and other injuries.

The fire department response was a three alarmer, with a total of nine engines, four trucks, three rescue squads, five ambulances, and three paramedic units involved, representing 113 personnel. The fire was extinguished within five minutes of the arrival of the first engine; within nine minutes of the smoke detector activation.

The 21 patients were evacuated from the B wing within 10 minutes of the first fire truck's arrival. All patients were evacuated within 25 minutes. The fire was confined to the room of origin and the adjacent corridor area.

Two patients died subsequent to the fire. One 92 year old woman, who had been in room 16 in the A wing, died April 16 of a heart condition. Another woman, 88 years old, from room 26 of the A wing, died April 24 of complications from smoke inhalation.

Diagram 1


Smoke detector
Fire
Light smoke
Moderate smoke
Heavy smoke
N
1A
17
19
21
23
25
1
2
3
4
5
6
8
10
12
14
Nurse Station
16
18
20
22
24
26
Kitchen
Lounge
7
9
11
15

The University Nursing Home, a privately owned and operated 150 bed Medicare and Medicaid Skilled Nursing Facility, had a 135 patient census at the time of the fire, 71% of whom were non-ambulatory. No one was in room 27 when the fire started. The total staff on duty that Friday morning were 22 nursing personnel and 10 other dietary, housekeeping and administrative personnel. There were 8 nursing personnel on B wing, a 6 to 1 patient to staff ratio. The patients ranged in age from 63 to 92 years of age.

Proper staff actions under stress undoubtedly prevented greater damage and injury. One reason for such actions could have been staff following assimilated fire safety training instructions.

Preparedness Pays

During 1979, the facility staff twice received training from a Montgomery County Fire Prevention officer, and also had inservice fire safety training from the facility administration. The training provided by the Division of Fire Prevention, Montgomery County Department of Fire and Rescue Services, consisted of several one hour lectures on general prefire planning, emergency procedures, instruction and practice in the use of fire extinguishers, evacuation methods, and case studies of lesson fires in other health care facilities. About one month before the fire, a representative of the Division of Fire Prevention had been to the nursing home to review the facility's entire disaster evacuation procedures, and fire manual. The facility administration provided staff training through their new employee orientation program.

By April 1979, when the fire occurred, two one-hour lectures, as well as the orientation program, had been completed by all staff. All had been trained as recently as one month before the fire.

An independent investigation of this fire by the University of Maryland Department of Fire Protection Engineering verified that staff training had been assimilated and resulted in proper actions. The University's conclusions were:

1. The critical initial staff action of closing patient room doors (with the exception of room 27) resulted in the reduction of patient casualties. This adaptive action was performed in an efficient and effective manner by the nursing staff, in a rapidly deteriorating and physically threatening environment;
2. The actions of the nursing staff with respect to the protection of the patients and alarm transmission were in conformance with the facility emergency procedures and appeared to have been determined by previous training; and
3. The eight staff persons taken for medical treatment was evidence of the threatening conditions under which staff acted to protect the patients.

Conclusion

Although there was, unhappily, some loss of life directly related to this fire, fires of a similar nature in similarly constructed nursing homes have caused greater loss of life and property. For example, fires at the Wincrest Nursing Home in Chicago, and the Cermak House in Cicero, Illinois in 1976, caused the deaths of 32 persons. Like the University Nursing Home fire, both of these fires originated in a resident's room, occurred in a facility of fire resistive or noncombustible construction which did not have nor was required to have sprinklers, and fire damage was essentially confined to the rooms of origin. In addition, the construction of the walls, floors, and ceilings was adequate to confine the fires to these rooms in all three facilities. Reports of the Illinois fires indicated there was insufficient time for the nursing home staffs to safely evacuate the occupants from the areas directly exposed to the smoke and heat of the fires.

What happened in Maryland (staff actions) should be more routine and should occur everywhere. Institution staffs should routinely receive fire safety training to help prevent these problems.

Most local fire protection agencies are willing to conduct fire safety and disaster drill training sessions on request. They are also willing to stage drills and evaluate staff performance. This is a free community service available to nursing home administrators. Local fire departments also will not only assist in developing written fire safety and evacuation procedures, but will suggest strategic places where emergency procedures and evacuation plans should be posted.

The relative "success" of the University Nursing Home fire underscores the importance of preventive action and planning. Tragic fires that result in loss of life and property often provoke stricter laws and tighter enforcement. While

useful, such laws and efforts are generally a crisis reaction and may not have been well reasoned.

Currently, it is a popular posture that government overregulates and many regulations are unnecessary. This article does not engage in that debate. The University Nursing Home fire is one case where the application of government regulations paid off and prevented the loss of many lives. All actors involved took the regulations seriously, including the nursing home staff and the local fire department.

Federal, State and local program staff managing human services programs have a wide range of responsibilities. In HCFA programs, these responsibilities include not only assuring good health services delivery but also the safety of the environment in which such services are delivered. Fire safety is one aspect of these responsibilities where assistance can be readily obtained from experts — the fire department.

Such performance can be replicated in other parts of the country. Further details concerning the establishment of such training programs and procedures can be obtained by contacting Sergeant Paul Mindte of the Montgomery County Division of Fire Prevention, Department of Fire and Rescue Services, 6110 Executive Boulevard, Room 435, Rockville, Maryland 20852, Telephone: (301) 468-4153.

Dr. Caldwell has been Director of the Division of Long Term Care since April 1978. Prior to that, she did an extensive review of HCFA's Fire Safety Enforcement Program, resulting in significant changes in policy and procedures. Her doctorate in Health Administration is from the School of Public Health, University of North Carolina, Chapel Hill.

AN ANALYSIS OF MEDICARE REIMBURSEMENT POLICY FOR PROVIDER BASED PHYSICIANS

by MICHAEL J. BROWN and LEE DILLON

(EDITOR'S NOTE: *This article was developed from a paper presented at a Fiscal Intermediary Group (FIG) meeting in June, 1978. FIG represents all intermediaries in the Medicare program, both Blue Cross Plans and the commercial intermediaries. FIG and the Carrier Representative Group (CRG), which consists of Blue Cross, Blue Shield, commercial and independent carrier representative executives, perform the consultative function for Medicare. An article on the consultative process appeared in the September 1979,* Perspectives.

Several definitions of terms are essential to understanding the issues presented in this article. First, intermediaries are organizations which have contracted to process claims from hospitals, skilled nursing facilities and home health agencies under Part A of Medicare. Second, carriers are organizations which have contracted to process claims under Part B medical insurance of Medicare. Third, provider, as used in this article, refers to institutional settings.)

Introduction

Medicare intermediaries, as represented by the Provider Reimbursement and Audit Technical Advisory Group,[1] are concerned about the apparent lack of solutions to reimbursement problems for provider based physicians.[2] These problems are evidenced by frequent discussion of provider based physician reimbursement in Provider Reimbursement and Audit TAG meetings, voluminous correspondence, and many other meetings involving HCFA staff, and intermediary and carrier staff.

Providers too are concerned with the methods and amounts of reimbursement paid provider based physicians. The situation is of considerable magnitude. Based on FY 1977 HCFA statistics, a minimum of 15.5 million forms were prepared to obtain provider based physician reimbursement. HCFA estimated that these forms required 3.4 million staff hours to prepare. Moving into the every day world, at the present minimum wage, without fringe benefits or taxes, this paperwork would cost the health care industry approximately $9 million to prepare. This figure includes neither the cost of obtaining the data, nor of collecting any portion of payment owed by the patient for physicians' services. Understandably, intermediaries continue to receive informal requests from providers for methods to limit (or for intermediaries to limit) selected physician reimbursement; the providers themselves feel powerless to hold down increases requested by their staff physicians.

These problems also impede the effective operation of the Medicare program, and arise from a number of sources. The Health Insurance Manual (containing instructions and procedures for intermediaries) does not clearly define certain key concepts (e.g., "provider based physician," "fee-for-service").[2] Clear definitions of such concepts would help solve the problems addressed later in this article. Changing conditions and practices of provider based physicians are not met with adequate program instructions. For example, there have been no amendments to Medicare's provider based physician reimbursement regulations since they were first promulgated on October 18, 1966; however the general instructions have been modified.

In these austere times, contractors are being reviewed more frequently by government to check adherence to Medicare's reimbursement policies, but the absence of clear definitions and guidelines makes uniformity difficult. This article will identify reimbursement areas needing immediate attention that are capable of resolution. Three problem areas are discussed and solutions recommended which can be achieved without legislative reform.

Reasonableness of Compensation

Radiologists and pathologists are compensated by the provider at a percentage of departmental charges, or by fixed salary, and, therefore, may send claims to the Medicare program using combined billing. But, they have no limitation applied to their compensation. More correctly, the *provider* has no limitation applied to this compensation.

Medicare regulations state that amounts payable under the hospital insurance program and amounts payable under the supplementary medical insurance program will be related as closely as possible to the level of compensation that the parties have agreed upon. However, we believe this section is a general statement of policy which must be implemented through specific policy in other sections of the regulations.[3] Using these sections, we believe reimbursement to provider based physicians could be limited.

Under Section 405.487(b)(2)(4), the Medicare intermediary approves that portion of a physician's compensation reimbursable to the provider; the carrier, in turn, determines the provider's reasonable charge. Note the use of provider in this article refers to institutional settings.

With respect to carrier responsibility, Section 405.485(b) states "...the schedule of charges will be subject to revision in the light of changes in the prevailing levels of compensation; (that) the assumption that the present level of compensation of the hospital based physician is reasonable (and that) assumption, of course, is open to challenge in any given case, and carriers must deal with such challenges on the basis of prevailing rates of compensation in comparable institutions." With respect to intermediary responsibility, Section 405.451(a)(5) mandates that all cost paid under provisions of 1861(v) of the Social Security Act, must be the "reasonable cost of services."

It is our opinion that these last two provisions offer administrative foundation to establish limits on the compensation of provider based physicians, independent of the provisions of Section 405.481.[4]

Where a radiologist or pathologist is compensated on a percentage of departmental charges, or by a fixed salary, the billing method elected by the provider may result in differing payment from Medicare Part B. If the provider elects combined billing, the Part B trust fund pays the full cost of services rendered by the radiologist and pathologist. If the provider bills the program via the HCFA-1490 with payment reassigned, such charges would be limited by application of the carrier's reasonable charge screens, if the charge exceeds the screens. After carrier review, the provider may receive more or less than its cost for the radiologist's and pathologist's professional services. If the provider bills the patient, the patient may receive the full amount of payment (less 20% coinsurance, if outpatient) or may receive less than his/her cash outlay where the amount billed exceeds the carrier's reasonable charge screen. These three cases illustrate that different payments for professional services occur, based simply upon the billing method. In all cases, no limit is placed on the Medicare portion of the cost for hospital services.[5]

Proposed Solutions: The Provider Reimbursement TAG recommends that HCFA require providers using combined billing to submit a complete financial analysis, including a detailed schedule of charges for each contractual arrangement between the hospital and the radiologist or pathologist. This analysis should contain sufficient detail to allow the carrier to make a determination of the reasonableness of charges for the individual physician services. The carrier's approved schedule of charges would be communicated to both the intermediary and provider. It could be used by the provider, subject to intermediary audit, in determining Medicare's liability for the physician's services in the cost settlement process. This procedure is supported by Sections 405.485(b) and 405.487(b)(2); however, general instructions requiring such limitations would have to be published.

This proposed solution may increase administrative costs, and accelerate physician movement toward billing either by assignment or to directly bill the beneficiary. HCFA should, however, attempt to determine any effect on the beneficiary, and whether savings realized would exceed increased administrative expenses, before implementing such a solution.

Another way to limit professional service cost would be to obtain the schedule of charges and the expected frequency of each service from the provider. From this data, professional revenue could be projected and compared with the amount determined, by multiplying the fre-

quencies of service and the reasonable charge screen. If the limitation set is the lower amount, the provider is informed of the maximum acceptable level of professional charges.

A third method of measuring reasonable compensation would be to establish maximum hourly rates, such as those utilized in PSRO and Renal Disease Network reimbursement. Such rates could be applied to total administrative and professional compensation.

Recommended Solution: We recommend that a combination of the first and third solutions be allowed; both are supportable under current regulations. If the provider chose not to supply the information required for the second method, then the limitation would be computed under the first method.

Provider Billing for Patient Services by Physicians (HCFA-1554)

There are multiple problems with billings on the HCFA-1554. Some of them are:

1. Providers who customarily separate their charges for physicians' professional service from their charges, are allowed to submit HCFA-1554 billings.[6] This practice appears contrary to instruction but is currently permitted.
2. Certain billings are impossible to screen. Providers bill per diem or per outpatient services on the HCFA-1554. These bills do not identify specific services rendered, and therefore, cannot be compared to reasonable charge screens. Providers with scheduled charges are permitted to aggregate multiple services within a department. Thus, the carrier is not informed of the detailed services rendered, and cannot subject that department's charges to the reasonable charge screens.
3. Even where the carrier does have sufficient information to compare the HCFA-1554 charges to the reasonable charge screen, any reduction in payment would be temporary, because of the intermediary's over/under billing adjustment performed at cost report settlement.

The schedule of professional charges billed to the program on HCFA-1554 is estimated by the provider, and reviewed by the staffs of the intermediary and carrier to ensure that this estimate complies with general program instructions.[7]

In practice, these charges are a translation of a physician's estimated total compensation into a schedule of charges based upon two other estimated factors, explained as follows. The procedure for determining the professional charges starts with an estimate of the physician's total compensation. The provider is required to determine an amount approximating total earned compensation, plus the cost of those fringe benefits applicable to the physician. While it may be possible to determine exactly the compensation to be paid the physician from a long term contract, it is virtually impossible to project accurately the cost of such fringe benefits as group life insurance, health insurance, employee parking, malpractice coverage, etc.

The physician is then asked to estimate time spent giving patient care versus time spent in hospital functions. This estimate is subject to change at any time. The physician may take on added duties, either professionally, or in the administration of the hospital or department. Or, after a period of time, the physician may realize that the initial estimate does not properly reflect actual division of time and will wish to correct it.

Finally, the provider is required to estimate the departmental volume, either in terms of revenue, number of procedures or number of patient days/outpatient visits. All of these are subject to change.

These estimated factors will certainly cause the fees recorded on the HCFA-1554 to vary from the desired result: for the total fees billed to all patients to equal the total professional service compensentation paid to the physician. Some carriers are comparing these charges with their reasonable charge screens and making reductions in payments based upon this procedure. However, as mentioned, this does not result in a permanent reduction in payment, since the intermediary is required to make a retroactive adjustment for all physicians' services billed on the HCFA-1554.[8] It appears, then, that manual instructions which clearly provide mechanisms for implementing the Medicare program's stated intent are needed.

Proposed Solutions: The first possible solution would discontinue use of the HCFA-1554. Providers could submit combined billed charges or fee-for-service for all outpatient professional services, except psychiatric (which may never be

combined billed). For inpatient radiology and pathology professional services, a similar method could be used, but must be consistent with the corresponding outpatient billing method. For inpatient professional services other than radiology and pathology, the provider would be required to bill the program or the beneficiary on a fee-for-service basis. Again, HCFA should review the trade-off between benefit payments and administrative costs. This may highlight the problem of services rendered when per diem billings are used.

The second proposal would transfer from the carrier to the intermediary the responsibility for determining program payment for services billed on the HCFA-1554. Under this procedure, the claims would be processed with their corresponding bill for provider services. The Part B payments made could then be treated as interim payments on the retroactive adjustment at cost report settlement. The cost of services could then be the actual cost of such services, or the actual cost, subject to some maximum hourly rate or maximum rate determined through other methods.

The third proposal would expand the areas where combined billing is allowed. This would accomplish the results in the second solution, with less paperwork for the provider.

Recommended Solution: The first and third proposals combined would reduce program administrative costs and possibly reduce the providers' costs as well.

Billing Methods

A provider that has obtained the right to bill for physicians' services, has four alternatives. These are: billing the patient directly; billing the intermediary via combined billing (HCFA-1453 and/or HCFA-1483); billing on an assigned or unassigned provider billing form (HCFA-1554) for physician services; or billing the carrier on an assignment of fees (HCFA-1490).

Direct Billing to Patient: Under current instructions, the intermediary is only responsible for collecting information concerning the contract and certain other factual data, where the provider elects to bill the patient. By increasing the number of claims submitted from beneficiaries and reducing the assigned and reassigned claims submitted by providers and practitioners, the workload and administrative costs of the carrier will be increased. For the beneficiary, such an arrangement increases the possibility that the beneficiary will be liable for service costs in excess of the Part B deductible and coinsurance. Because of the potential additional cost and burden on the beneficiary, we are concerned with the increasing trend towards this method of billing.

Where a physician leaves the provider's employ and begins to directly bill the program or patients for services, HIMs-13 and 15 set forth certain principles for reimbursing the provider, and establishing the reasonable charge screen for the physician's services. Currently, many problems arise in attempting to implement these principles. There are no clear procedures for converting a physician from billing in a provider setting to an independent status.

Proposed Solution: HCFA should attempt to determine why such a trend exists and take steps to counteract the problem. This may also require legislative initiative.

Program instructions should also more definitively explain the principles for conversion to fee-for-service billing. Such instructions might include a three month prior notice requirement, and forms or exhibits to develop to reasonable charge screen to be used for physicians during this conversion period. Such a charge screen should also develop a limitation on the hospital's administrative costs, in accordance with HIM-15.

Combined Billing: There is concern over the reasonableness of the compensation paid to pathologists and radiologists, and the reimbursement of that cost through the combined billing method.

Another aspect of combined billing merits discussion. Under current program instructions, if the provider and physician contract to pay the physician a set fee when he/she performs services and such services are rendered to an outpatient, the provider is required to submit two billing forms, one for the provider services (HCFA-1483) and one for the physician's professional fees (HCFA-1554 or HCFA-1490). Thus, the contractor's and the provider's administrative costs are doubled, without any increase in productivity or quality of patient care.

Proposed Solution: In the interest of containing health care costs, we suggest that the program revert to the policy in effect prior to 1971, so that all provider based physician fees for outpatient

services, with the exception of psychiatric services, are combined in billing. Such a change would avoid numerous claims for small dollar amounts, and would not increase the program's administrative or benefit costs. In fact, this would be less costly than separate billing, under a strict interpretation of the present requirements.

Billing Form HCFA-1554: Previously we addressed problems inherent in carrier's subjecting HCFA-1554's to reasonable charge screens. We see an additional problem in the lack of adequate information concerning disbursements made to providers by the carrier.

In order to make an accurate settlement of a provider's cost report, including adjustments for HCFA-1554 billing, an accurate record of charges submitted to, and payments made by the carrier, by type of service, is necessary. Currently, the intermediary must rely solely on the provider's records. HCFA intermediaries and their auditors do not have the capability to accurately calculate the over/under billing adjustment. The provider may be unable to reconcile carrier payments to specific ancillary charges billed, and so would be unable to compute over/under billing adjustment.

Proposed Solution: The preferred solution is to eliminate the HCFA-1554 billing form. As previously stated, the provider could then combine bill, where applicable, the Part B carrier on a fee-for-service basis, or the patient could be billed directly. We have addressed the latter point earlier.

If this solution is not adopted, those carriers currently checking HCFA-1554 billings against reasonable charge screens should be required to end such activity. Such screening could be replaced by the accumulation of data submitted and paid for on HCFA-1554's. This diversion of resources would save the Part A auditor's administrative time and enhance the quality and accuracy of settlements. The summaries of claims should show total charges, deductibles, coinsurance, denied claims and payments by department, for each provider fiscal year. HCFA should determine whether the benefits from increased accuracy of cost report settlements and the decrease in intermediary administrative cost would exceed the increase in carrier costs and so justify the change.

HCFA-1490 Billings: Changing technology has raised issues about jurisdiction of the Part B carrier. A case in point involves the professional component billings generated by a hospital for charges for reading telephonically transmitted cardiology tests. Medicare policy, as expressed in HIM-14, settled the jurisdictional issue by designating the carrier in the area where the reading computer and physicians are located as the processor of such claims. This policy was established prior to current technological capabilities. A more current example, illustrating the effects of technology, also underlines the jurisdictional issue:

For example, a contracting cardiology company located in Chicago reads an electrocardiogram of a patient in a Florida hospital. The cardiology company bills the hospital, which in turn must bill the Chicago carrier of jurisdiction. On the other hand, designating a carrier other than the one with which the provider and its intermediary are accustomed to deal, introduces decreased control of the situation.

The local carrier is in communication with the provider, the intermediary and the attending physician. But, the carrier in the area of the cardiology company is processing claims for tests performed on beneficiaries all over the country. Only the local carrier would be able to monitor the necessity of overreads performed by physicians at the hospital.

A similar situation exists where a physician interprets diagnostic tests, etc., away from the hospital where tests were conducted. Such services are rendered on behalf of the hospital's patients. The hospital and the physician have a financial arrangement which requires the hospital to pay the physician for the professional services. Under certain interpretations of "provider based physician" (see footnote 2), this arrangement does not qualify as a provider based physician arrangement, because the physician's reading is not performed on site.

Proposed Solution: We suggest that an exception be made to current instructions for processing forms HCFA-1490 and HCFA-1554. Where a provider bills for telephonically transmitted diagnostic tests, the claim should be processed by the carrier with which the provider deals for all other services of hospital based physicians. This would recognize a change in technology not anticipated when carrier jurisdiction rules were originally published.

A second solution would require that the determination of whether services are rendered by

provider based physicians be judged by the patient's status rather than the physical location of the physician. The artificial distinction between the physician's rendering services at the provider site versus off site would be eliminated. The alternative criteria should be that the physician renders services to patients of the hospital, and receives remuneration from that facility for these services, or the provider/physician arrangement meets the criteria of Section 227 of Public Law 92-603 (teaching physicians). If the services were given in either of these situations, the physician would be considered provider based. Tables 1 and 2 illustrate examples of various billing options.

TABLE I : Examples of Billing Options

(These examples illustrate the application of the various billing options to a single set of assumed circumstances. The effects of these elections on payments to the hospital and the physicians and/or the payments made by the Medicare program and by its beneficiaries are shown. The summary in Table 2 compares these effects.)

ASSUMED CIRCUMSTANCES :

Provider—Radiologist

Compensation—40% of Total Charge

Assumed—100% Professional Component

Total Charges to beneficiary for provider and professional inpatient services—$100

Professional Component—$40

Carrier's Reasonable Charge for the Service—$25

Beneficiary has both Part A and Part B coverage and has met the Part B deductible.

EXAMPLE A :

Beneficiary is billed directly by provider (physician) for the $40 professional fee.

Patient will pay provider (physician) $40

Patient will bill carrier $40 on HCFA—1490. Carrier will only reimburse $25.

Patient is out of pocket $15.

EXAMPLE B :

Hospital bills carrier $40 on HCFA—1490 (with assignment and reassignment).

Carrier pays hospital the reasonable charge of $25.

Hospital pays physician $40.

Hospital is out of pocket $15.

Beneficiary pays nothing.

EXAMPLE C (1) :

Hospital bills carrier for several services including the $40, on HCFA—1554.

Carrier pays hospital full amount billed, including $40, as reasonable charge screens cannot be applied.

Hospital pays physician 40% of billed charges, including $40.

Beneficiary pays nothing.

EXAMPLE C (2) :

Hospital bills carrier $40 on HCFA—1554 (with assignment and reassignment).

Carrier pays hospital the reasonable charge of $25.

Hospital pays physician $40.

Beneficiary pays nothing.

Intermediary pays hospital $15 as under billing adjustment at cost report settlement.

EXAMPLE D :

Hospital bills intermediary $100 on HCFA—1453 (Combined Billing).

Intermediary pays hospital interim rate on $100. Cost report settlement will adjust the professional component to $40.

Hospital pays physician $40.

Beneficiary pays nothing.

TABLE 2 : Summary of Examples

Example	*Hospital*	*Carrier*	*Intermediary*	*Physician*	*Beneficiary*
A. Direct Bill to Beneficiary					
Payment to physician				($40)	$40
Carrier pays beneficiary		$25			($25)
Beneficiary's loss					$15
B. Hospital 1490 to Carrier					
Payment to physician	$40			($40)	
Carrier pays hospital	($25)	$25			
Hospital's loss	$15				
C(1). Hospital 1554 to Carrier					
Payment to physician	$40			($40)	
Carrier pays hospital	($40)	$40			
	0				
C(2). Hospital 1554 to Carrier (Screened)					
Payment to physician	$40			($40)	
Carrier pays hospital	($25)	$25			
Intermediary pays hospital	($15)		$15		
	0				
D. Combined Billing					
Payment to physician	$40			($40)	
Intermediary pays hospital	($40)		$40		
	0				

Legend: Figures in parenthesis—$ received, Figures without parenthesis—$ paid.

Conclusion

Three specific problems have been examined, and solutions suggested that are feasible within existing law and regulations. With one possible exception, the solutions would only require changes to general program instructions. Changes are needed to restore some order to complex provider based physician reimbursement. With the passage of Public Law 95-142, requiring standards of intermediary performance and the intense focus on fraud and abuse, we believe these problems must be faced.

We suggest that a committee of the co-chairmen of the Claims, Reimbursement and Audit TAG's and of the carrier claims, work with HCFA staff to solve these problems.

(EDITOR'S NOTE: *As a further step in the consultative process, the issues raised in this paper and others regarding provider based physician reimbursement are now undergoing intensive review and analysis by HCFA staff.)*

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NOTES:

1. The Provider Reimbursement and Audit Technical Advisory Group is a group of contractor and HCFA technicians who specialize in the development of Part A reimbursement policy procedures.
2. The definition of provider based physicians comes from HIM-15-1, Section 2108(A) which states, "These instructions apply where physicians perform services in provider settings and have a financial arrangement under which they are compensated by or through a hospital." Further, HIM-10, Section 400.5(A)(7) states, "The physicians are compensated by salary, or receive a percentage of charges.

Where a physician charges a fee-for-service, the combined billing method cannot be used."

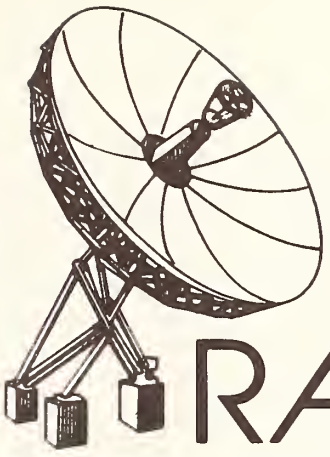
3. Section 405.485 (b)—"Development of schedules. Since the present almost universal practice does not separate the professional services to individual patients from the other components of hospital-based physicians' services, for purposes of determining the manner or amount of compensation, it is necessary to devise a method for making this separation. The approach set forth in this section starts with the assumption that the present level of compensation of hospital-based physicians is reasonable. The assumption, of course, is open to challenge in any given case, and the carriers must deal with such challenges on the basis of prevailing rates of compensation in comparable institutions. Over a period of time, the schedules of charges will be subject to revision in the light of changes in the prevailing levels of compensation."

   Section 405.487(b)(2)—"Such allocation (made in accordance with 405.484) should be capable of substantiation by the hospital and the physician. The parties' determination and supporting information should be reviewed by the hospital insurance intermediary and the carrier. The intermediary will be responsible for the approval of the portion of the physician's compensation which has been determined by the parties to be a cost which is reimbursable to the hospital and the carrier will be responsible for the approval or disapproval of the parties' reasonable charge determination."

   Section 405.451(A)—"All payments to providers of services must be based on the reasonable cost of services covered under Title XVIII of the Act, and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under Title XVIII of the Act, and furnished to program beneficiaries or the customary charges to the general public for such services, as provided for in 405.455."

4. Section 405.481—"The principles in this Subpart D are designed to give recognition to the arrangement entered into by a hospital and a physician, by establishing criteria for determining, within the framework of the arrangement, amounts payable under the hospital insurance program and amounts payable under the supplementary medical insurance program, to the end that the total payments with respect to the physicians' services to the hospital and for the patient are related as closely as is possible to the level of compensation the parties have agreed upon."
5. Section 405.480(g)—"In order to make payments under Title XVIII of the Act, however, it is necessary, where billing is by or through the hospital, to distinguish between the medical and surgical services rendered by a physician to a patient on the one hand, and the hospital services (including physicians' services for the hospital), on the other.
6. HIM-10, Section 400.4—*"HCFA-1554, Provider Billing for Patient Services by Physicians*—This form is submitted to the Part B carrier to obtain compensation related reimbursement, if:...The hospital does not customarily identify charges for the physician's services separately from the charges for provider services, and is not in the process of establishing customary charges for the services;..."
7. HIM-15-1, Section 2108.11—See exhibits I through IV. In every method of determining the schedule of professional charges, at least one estimated factor is utilized.
8. HIM-15-1, Section 2107(A) and 2108—"Where a provider has been overpaid or underpaid for the patient care services of a provider-based physician, the Part A intermediary will make an appropriate adjustment as part of the provider's final cost settlement where:

   1. The provider billed on form HCFA-1554, and
   2. The charges were based on the physician's compensation."



RADAR

Research and Demonstration Activity Report

Entering a Nursing Home—Costly Implications for Medicaid and the Elderly

This General Accounting Office study is recommended reading for all concerned with long term care.

The report covers not only Medicaid's role in long term care, but also considers that of other Federal or State programs, ranging from Title XX services to Administration on Aging to Housing and Urban Development, and represents a highly thoughtful and comprehensive assessment of long term care services delivery in this country. The author points out: "Medicaid's role in financing nursing home services nationally is significant because it spends more on this care and supports more individuals in nursing homes than any other public or private source. Thirteen percent of nursing home residents (97,000) in 1969 used Medicaid funds as their primary source of payment; by 1977 this had increased to 48 percent of all residents (623,000). During this same period there were declines in the proportion of residents using Medicare, their own income, or other public assistance or welfare as the primary source of payment. Most of the decrease in the number of residents supported by 'other public assistance or welfare' resulted from the transfer of the intermediate care facility services from cash assistance programs to the Medicaid program on January 1, 1972."

The impact of nursing home coverage on Medicaid is discussed, including the fiscal effect of long term care on the program. GAO points out that 74 percent of the States spent 40 percent or more of their total Medicaid expenditures on nursing home care, and that in 19 States, 50 percent or more of their budgets went for long term care. (See Figure 1).

Focusing on the elderly, since they represent the majority of long term care patients, GAO added that many of their findings would apply to such patients as the mentally retarded since the systemic problems identified serve to encourage the institutionalization of these persons also.

FIGURE 1 : Nursing Home Expenditures As a Percentage of Total Medicaid Expenditures by State, FY 1978 (note a)

South Dakota	67.8	Alabama	45.8
Minnesota	64.2	Vermont	45.2
Alaska	63.2	Georgia	44.7
New Hampshire	62.2	South Carolina	44.6
Colorado	60.5	New York	44.3
Wyoming	60.5	Kansas	44.2
Iowa	58.1	Hawaii	43.8
Texas	58.1	Rhode Island	43.3
Nebraska	57.8	Kentucky	41.7
Wisconsin	56.9	Mississippi	41.1
Idaho	56.7	Florida	40.3
Arkansas	55.5	Ohio	40.0
Montana	54.0	North Carolina	39.8
North Dakota	53.8	Delaware	39.7
Connecticut	53.1	Michigan	39.3
Indiana	53.1	Missouri	38.8
Oklahoma	52.8	Massachusetts	38.7
Utah	52.5	Washington	38.4
Nevada	51.0	New Jersey	36.4
Oregon	48.9	Maryland	34.3
Maine	48.4	New Mexico	31.3
Pennsylvania	47.6	Illinois	29.5
Louisiana	47.0	California	23.9
Virginia	46.3	West Virginia	22.5
Tennessee	46.0	District of Columbia	13.1

[a]Arizona does not have a Medicaid program. Guam, Puerto Rico and the Virgin Islands are not included.

And, GAO adds, "These figures underestimate all Medicaid expenditures for patient care in nursing homes because they do not include the cost of physician services, drugs, medical equipment and other medical services" reimbursable for long term care patients.

Avoidable institutionalization and inappropriate placement are also discussed and focus is placed on problems in the nursing home admission process. Medicaid policy with its built-in bias toward institutionalization—policy that permits persons who would not have qualified for Medicaid outside of the institution to become qualified because of the fact of their institutionalization—is addressed. GAO points out the complexity of arranging appropriate services for the elderly, caused by fragmentation and lack of coordination in the long term care system—a system described as a conglomeration of Federal, State and local programs, with separate administration, eligibility and financing. (See Figure 2.) The importance of preadmission review in preventing nursing home placement is covered, with discussion of Medicaid review systems and State efforts in this area. One chapter documents State and local success in reducing avoidable nursing home placement, going into brief individual description of these undertakings. GAO's conclusions summarize "the factors contributing to avoidable utilization of nursing home by Medicaid patients." They are:

> "As long as Medicaid's nursing home coverage is the only readily available source of financial assistance for long term care, many chronically impaired elderly will be placed in nursing homes even though this is a more intensive care level than is needed.
>
> Financial barriers to obtaining community-based long term care are only one of the factors contributing to avoidable nursing home utilization.
>
> Medicaid cannot adequately control avoidable nursing home utilization because of inadequate assessment mechanisms and lack of authority to screen all applicants for admission.
>
> Reliable projections of the need for nursing home beds cannot be made using current nursing home utilization data.
>
> State and local efforts to reduce Medicaid support for avoidable institutionalization are impeded by the fragmentation and gaps in Federal long term care funding and the current structure of the Medicaid program."

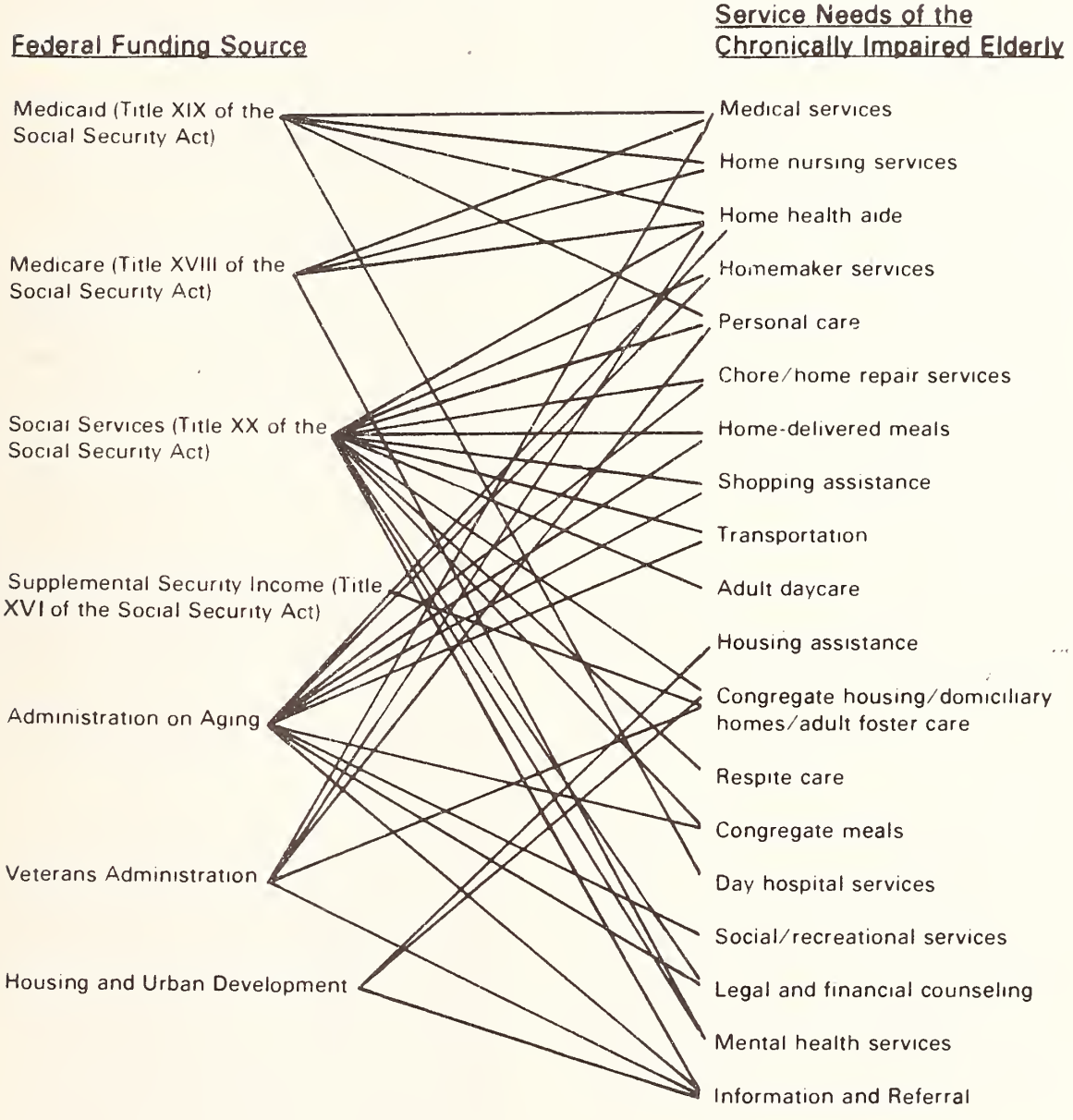
To address the problems identified, GAO reported to Congress: "Specific changes are needed to assure that Medicaid funds are spent effectively to meet the long term care needs of the chronically impaired elderly and to reduce program expenditures for avoidable institutional care. There are significant problems, however, in proposing solutions to the causes of avoidable nursing home placement.

First, many individuals are admitted to nursing homes because of gaps or inadequacies in the health, social service, income support, housing or medical insurance systems. Attempting to remedy these deficiencies would require changes in numerous legislative and administrative rules cutting across a wide spectrum of programs—changes which would go beyond the scope of a particular facet of the long term care system. Second, despite the potential human and financial advantages of developing and increasing community and in-home health and social service options for the elderly, there is little information or even agreement on how best to organize the comprehensive changes needed.

Finally, there is no reliable information on the number of individuals who need or would use community services for different levels of functioning ability in lieu of nursing home care. In large part this is due to the current unavailability of such services. This makes it difficult to estimate the costs and the systemwide effects of any recommended policy changes. At the same time, until there is a move toward a more comprehensive and integrated system for delivering care for older persons, most of these current questions will remain unanswered.

In spite of these constraints, certain steps can be taken toward increasing the choices older people have when they need long term care and for assuring that Medicaid expenditures for avoidable nursing home use are minimized. In view of the strong Congressional interest expressed in recent years for legislative recommendations with respect to all aspects of the delivery of home health and other in-home services, we are proposing, in general terms, an approach aimed at providing the elderly with a viable option to institutional care." GAO's approach includes: establishing a preadmission screening program to serve nursing home applicants and assigning responsibility for

FIGURE 2: MAJOR FEDERAL PROGRAMS FUNDING COMMUNITY SERVICES FOR THE ELDERLY



administering the preadmission screening program to one agency.

HEW* generally agreed with GAO's findings, but raised some issues for consideration:

Assessment—HEW supported preadmission assessment but raised some cautionary notes. HEW believes that assessment itself is expensive and may not be cost effective, and noted that assessment tools now available are far from comprehensive and need further development and testing. They suggested that capabilities of health and social service professionals nationwide must be determined, and skills developed before a preadmission screening program could be implemented.

Service Fragmentation—HEW stated that the components of a preadmission patient program would be considered in a demonstration project, and that prior to implementation nationally further testing is needed. They also questioned whether GAO's approach would add a new program to an area already overloaded with programs, causing further fragmentation.

Control Over Cost Utilization—HEW agreed that incentives should be incorporated to control cost and utilization, but had problems with the GPO option proposed. For example, tying community care costs to rising nursing home costs could work as a disincentive to States to fund community care, HEW indicated.

Health Departments—The preadmission screening programs could be set up as a separate entity or incorporated as part of an already established program. GAO suggested as one option that it be located in HEW with responsibility for its administration assigned to the State and community public health departments. HEW agreed that this would be considered in a demonstration. At the same time, they pointed out adding another program could further fragment administration of the long term health/social service delivery and financing programs. HEW also had problems with locating the program in health departments.

HEW currently has a task force of representatives from the Administration on Aging, the Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation. The task force is to develop guidelines for establishing and evaluating methods for delivering long term care. Beginning in FY 1980, HEW will spend approximately $20 million to test the effectiveness of assessment, case coordination, and monitoring agencies at the local level.

Single copies of this report, "Entering a Nursing Home—Costly Implications for Medicaid and the Elderly," PAD-80-12, are available free of charge from the U.S. General Accounting Office, Distribution Section, Room 1518, 441 G Street NW, Washington, DC 20548.

Study of Quebec Health Insurance

The impact of compulsory health insurance in the Canadian province of Quebec is examined in this study, funded by HEW's National Center for Health Services Research, and conducted by professors at the University of Pittsburgh and McGill University.

Through a series of telephone and household surveys and interviews before and after the introduction of Quebec Health Insurance (QHI) on November 1, 1970, the researchers focused on four areas of impact: use of physician services by the general population; the workload of physicians; the use of emergency rooms; and a hospitalization and surgical study. While the researchers identified trends within each of the four areas, they emphasize that no conclusions can be drawn about the overall effects of QHI on the health of the population.

QHI Effect on Physician Visits: The survey showed there was no significant change in physician visits reported by the 6,000 households interviewed before and after the introduction of QHI. However, there was a difference in the usage of physician visits based on income, leading researchers to theorize that economic barriers to physician utilization existed prior to the enactment of QHI. While persons in the lower socioeconomic ranges visited the physician more than they had before QHI, persons in the higher economic ranges decreased their visits.

QHI appeared to be responsible for increasing the average waiting time for an appointment from 6 to 11 days. Time waiting in doctors' offices also increased several minutes, the researchers report.

The study showed that physicians were more frequently seen for important medical symptoms,

*Now the Department of Health and Human Services.

indicating that removal of the financial barrier to health/medical care led more ill people to seek treatment, thereby improving the general health of the population.

Effect of QHI on Physician Workload: Researchers noted little change in the total number of practicing physicians, their age distribution, nor in their source of training. Physicians appeared to employ more secretaries and nurses, and fewer bookkeepers. Physicians' time in the office increased although time spent in other settings, including hospital and home visits, declined. Researchers attribute the increased office time to increased pressure for service by patients. While general practitioners increased their work, other physicians and psychiatrists substantially reduced theirs.

QHI Effect on Utilization of Emergency Rooms: After QHI, the study showed no significant difference in the characteristics of persons using emergency rooms, except for a slight increase of children. The authors suggest that there was a possible shift in the site of medical care delivery from the office to the emergency room.

QHI Effect on Hospitalization: Researchers found differences in types and frequency of surgical procedures between Montreal and other cities, which they could not explain.

Conclusion: While the researchers could not draw any conclusions on QHI's effect on the health of the population, they found some interesting, possibly predictable, results.

First, lower income persons utilized physicians' services more frequently after QHI, possibly because financial barriers were eliminated. Physicians worked shorter hours after QHI, and spent less time in settings outside their office. They also saw a greater number of patients. Emergency room use increased, as did certain types of surgery; no decrease in hospital admissions was noted.

Copies of "Effects of Quebec Health Insurance" are available from NCHSR, Room 7-44, 3700 East West Hwy., Hyattsville, MD 20782.

Home Health Care Services

Because of Congressional concern about home health agency costs to Medicare, the General Accounting Office (GAO) conducted a study to determine the adequacy of Medicare's cost reimbursement procedures for home health care services. Normally, Medicare allows reimbursement for most claims if the cost claimed is reasonable, related to patient care, and within the same cost range of other agencies.

GAO selected for detailed audit home health agencies in Florida and Louisiana, and did limited audits at other agencies to verify that claims for Medicare reimbursement were in fact incurred, allowable, reasonable and properly reported. Agencies were selected according to type, location, size, and type and amount of cost claimed for Medicare reimbursement. GAO focused on proprietary and private nonprofit agencies because 1976 and 1977 Congressional hearings indicated possible abuse by these types of agencies. This report discusses GAO findings and recommendations.

Wide variances were found across the country in unit cost, with some agencies incurring excessive administrative and clerical costs. For example, in Dade County, Florida, a nonprofit Medicare - only provider incurred $310,400 in management and clerical expenses during Fiscal Year 1976, while the Broward County Visiting Nursing Association, in the same area, serving about the same number of patients and making about the same number of visits, incurred $132,600 in administrative costs. One agency in the Baton Rouge/New Orleans area incurred administrative costs of about $291,400 in Fiscal Year 1976, while another's operating expenses were about $129,000.

GAO proposed that HCFA develop cost limits by type of visit, and certain individual or group cost elements intended to provide further assurance that Medicare will reimburse only reasonable costs. HCFA has established reimbursement limits on costs per visit for home health agencies. The limits became effective July 1, 1979, and are presently applied on an aggregate basis. A revised schedule of limits, to be applied to each type of service, was proposed February 15, 1980 (45FR10450) to become effective July 1, 1980.

Physician services also varied significantly by agency. Agencies with staff physicians claim substantially greater costs than agencies that obtain medical advice on a consulting basis. Home health agencies that had staff physicians claimed that these professionals provided medical advice as needed, evaluated care and utilization, and consulted with attending physicians. The agencies did not have records that specifically documented physician activities. GAO concluded

that all of the agencies had nursing directors or supervisors who could have performed the daily supervisory services required by Medicare, and questioned whether staff physicians were needed, since some home health agencies were managing without them. In April 1978, HCFA issued an Intermediary Letter addressing the compensation paid to medical directors, and that requires home health agencies to document services provided by medical directors and the hours they worked. GAO also found that the number of employees of nonprofit agencies bear little or no relationship to the number of patients serviced or visits made.

Questionable Costs: Five of the home health agencies claimed fairly substantial costs that were undocumented and/or unrelated to patient care. These costs included travel abroad, expenses for restaurants, flowers for various individuals, a fishing trip, and country club membership. In these cases, home health agency officials could not explain how these expenses related to patient care, and acknowledged that personal expenses had been claimed for reimbursement. GAO said their review was limited to randomly selected expenses, therefore they could not determine the total amount of costs for claims unrelated to home health services, but it would be reasonable to expect that intermediary audits would have identified and disallowed some of these costs.

All agencies claimed some type of advertising costs in Fiscal Year 1976, for such expenses as sending brochures to hospitals, physicians, and patients. Under Medicare, advertising and promotional expenses of a general nature are allowable; patient solicitation is not. Some nine of the 11 home health agencies visited by GAO had full-time individuals serving as discharge planners or coordinators. Their primary function appeared to be soliciting patient referrals. Since hospitals and skilled nursing facilities are responsible for discharge planning, Medicare does not consider such activities reimbursable for home health agencies. Some home health agencies also claimed reimbursement for expenses such as gifts to hospital social workers and physicians. GAO questions whether such gifts, no matter how small, should be reimbursable since they are not related to patient care.

Home health agencies were reporting questionable fringe benefits through cost reports. For example, expenses for a Christmas party were reported under "stationery and printing." GAO believes that provider cost reporting is not sufficiently detailed enough to permit intermediaries to determine the nature and amount of various costs claimed.

GAO recommended that HCFA reemphasize Medicare's basic documentation requirements and require intermediaries to test for provider adherence; that program instructions should clarify the specific promotional activities that are reimbursable, including discharge planning activities; and that agency salaries and fringe benefits should be specifically reported. In 1979, HCFA published instructions based on GAO's recommendations. In light of concerns expressed by providers, HCFA is currently reviewing its policy regarding advertising costs.

The number of nonprofit home health agencies has increased in recent years. One reason: for-profit organizations help establish them, and subsequently do business with them. This relationship has created some Medicare program abuse. For example, the nonprofit agencies obtain services from the for-profit organizations without competition; some contracts for these services are of excessive duration and may be unnecessary for providing home health services. Some home health agencies' facilities were used to conduct business of the for-profit organizations at the expense of the Medicare program. HCFA Intermediary Letter 78-39 is designed to assist intermediaries in their evaluation of management contracts. HCFA has also developed a proposed revision of the Provider Reimbursement Manual on the subject of purchased management and administrative support services to further assist in the assessment of the allowability of costs that providers incur through such contracts. Currently, this revision is being reviewed by intermediaries and provider groups during the prior consultation period.

Single copies of the GAO report ("Home Health Care Services—Tighter Fiscal Controls Needed," HRD-79-17, May 15, 1979) are available free of charge from the U.S. Government Printing Office, Distribution Section, Room 1518, 441 G Street, NW, Washington, DC 20548.

Tax Subsidies for Medical Care

The Congressional Budget Office prepared this background paper at the request of the Subcommittee on Health and Oversight, House Ways and Means Committee. CBO examines the role medical care tax subsidies play in rising health care costs. Although this study offers no policy recommendations, it does identify and analyze the tax

exclusion of employer contributions to employee health insurance plans, the tax deductibility of health insurance premiums, and the use of tax exempt bonds to finance capital projects at private hospitals and medical institutions.

Along with the tax deductibility of contributions to not-for-profit medical facilities, these three tax exclusions are expected to account for Federal revenue losses (or Federal subsidies for health care) totaling over $14.5 billion during FY 1980. These items, which do not appear as direct Federal budget expenditures, as Medicare and Medicaid costs do, represent about one-fourth of Federal health care expenditures and affect the price and use of medical services. CBO indicates that these subsidies encourage increased use of health resources and the development of more elaborate forms of medical care.

The Employer Exclusion: The employer exclusion, expected to account for $9.6 billion in Federal revenue losses during FY 1980, stimulates health insurance coverage. The tax saving encourages both employees and employers to seek group health insurance providing full reimbursement for covered medical expenses; the exclusion lowers the cost of coverage, leading to increased medical spending. This exclusion encourages employees to buy and use more expensive forms of medical care due to less out-of-pocket expense; thus, total medical expenditures are raised. In addition, there is little incentive for employers to choose health insurance containing cost containment features, since they receive increased discounts for purchasing larger group policies and the tax exclusion is unlimited. CBO researchers found that actual tax savings are concentrated among higher income individuals because average tax savings rise with taxpayer income. However, many people do benefit from the employer exclusion by their coverage under group health insurance plans.

Alternatives: The researchers discuss and analyze three possible changes in current law which could reduce the inflationary effects of the employer exclusion and bring about a more equal distribution of tax benefits across income groups. The simplest of the three alternatives, to limit the employer exclusion to a fixed dollar amount, would encourage employers and employees to choose less inflationary health plans. Under this method, it is most likely that only plans with incentives to curb spending would be fully subsidized; additional coverage would have to be purchased with taxable dollars. A second alternative is that of replacing the employer exclusion with a tax credit. This would make all employer contributions to group health plans taxable income to employees, with a portion (ie., first $1,000) qualifying for an employee tax credit. This option can be expanded to provide benefits for taxpayers without group insurance and who do not itemize deductions. It also would allow the same rate of subsidy to all taxpayers for each dollar of qualifying employer contributions. The third alternative is requiring health plans that qualify for the exclusion to contain certain features: a minimum set of health benefits; significant cost sharing requirements (deductibles and coinsurance) for all services; or require employers to offer a choice of health plans, while contributing equally to each one. This option would help contain medical spending by encouraging competition between health care providers.

Medical Expense Deductions: The best known health care tax provision, the medical expense deduction, is expected to cost the government $3.1 billion in lost revenues during FY 1980. (Individuals who itemize on tax forms—approximately 28% of all U.S. taxpayers—deduct part of their health insurance premiums and other out-of-pocket medical expenses from their taxable income.) This encourages additional medical spending, CBO indicates, since it decreases the incentive to economize on medical expenditures. Another disadvantage of this tax provision is that the need for tax subsidies is considered greatest among low income families. However, this tax saving is disproportionately concentrated among the more affluent, especially since most low and moderate income individuals do not itemize. The researchers also note that tax refunds are not available until long after expenses have been incurred, and tax returns filed.

This study also examines three proposals for changing the way medical expense deductions are treated. The first, changing from a deduction to a tax credit (particularly a refundable one) for extraordinary medical expenses, would extend this benefit to taxpayers not itemizing. Such a change, however, could increase the government's revenue losses. The second proposal, raising the minimum deduction for out-of-pocket medical expenses to above the current 3% of adjusted gross

income, would reduce the government's revenue losses and be especially helpful to people with heavy medical outlays. Conversely, this alternative would raise many individuals' tax liabilities. Increased costs for high medical expenditures could be offset by providing a supplementary tax credit for such outlays above a certain percentage of adjusted gross income. The third proposal, replacing the deduction with "catastrophic" health insurance provided by the Federal government, would be especially helpful to low and moderate income persons with high medical expenses, but would be expensive to administer. In addition, this option could increase total medical spending if physicians and patients felt less constrained in using services because all "catastrophic" expenses would be covered.

Private Hospital Tax Exempt Bonds: Private hospitals, particularly tax exempt, not-for-profit facilities, are able to obtain low interest loans for capital projects through tax exempt bonds. The savings represented by these bonds are the largest form of Federal government support for hospital and other medical institution capital projects, expected to be about $400 million in FY 1980, or about half the funding for U.S. hospital construction.

In the past, government subsidies for hospital construction had been justified because of a shortage of hospital beds, particularly in rural areas. However, many researchers now believe that, for the U.S. as a whole, there is an excess of hospital beds, although individual areas may still have shortages. Despite this, and the creation of State agencies to monitor the growth of hospitals, hospital construction has continued to increase. Recent studies question the effectiveness of the State health planning agency process. Financially weak hospitals, which often need these government subsidies most, find State and local government agencies will not issue tax exempt bonds for them because of the facilities' weak credit ratings. In addition, hospitals receive only about 70% to 75% of the savings (subsidy) provided by tax exempt bonds. The remainder goes to bond purchasers as tax savings, and as fees for arranging tax exempt bond financing.

CBO believes the simplest option available to Congress for tax exempt hospital financing is to maintain current law. This would preserve the advantages of using tax exempt bonds as a subsidy, making such savings available without requiring prior approval from a Federal agency. However, this would also preserve disadvantages of using such bonds—uncontrollable expenditures, a regressive effect on the Federal tax system, and relatively high cost of providing funds to hospitals. If the present health planning process is not improved, maintaining current law would also leave the possibility that the subsidies would go for "unnecessary" projects, while deserving projects at financially weak hospitals will not be supported.

Another option, eliminating hospital construction tax exempt bonds, would prevent subsidizing hospitals with questionable needs, but, at the same time, would block many worthwhile projects from such subsidies. Since there are few other sources of subsidized funds for hospitals, to compensate, Congress could increase direct expenditure Federal subsidies for hospitals. To do this, however, restrictions imposed by current health planning rules would have to be modified. Such changes might weaken States' incentives to limit hospital capacity through regulation.

A third option, limiting tax exempt hospital bonds to "general obligation" bonds backed by the issuing government agency, would eliminate the present typical form of revenue bonds backed only by a hospital's income. This option would reduce the number of hospital projects financed by tax exempt bonds because each government unit has a ceiling on the volume of general obligation bonds it can issue without being forced to pay high interest rates or have its credit rating jeopardized. Thus, hospital projects would compete with others financed by a government unit's tax exempt bonds. If so, government agencies would scrutinize hospital projects more carefully and probably limit bond issuances to those projects with the greatest apparent public benefits. This could mean that the most worthwhile projects might not always receive these funds. Financially strong jurisdictions with high bond ratings might be advantaged under this option, even if their hospital projects were no more worthy than those in weaker jurisdictions with lower bond ratings.

Another problem inherent in this option is that it could preclude private hospitals in many States from receiving tax exempt financing. Many States have prohibitions against issuing private institution tax exempt bonds backed by the issuing government agency. In other States, hospital bond authorities are not allowed to issue general

obligation bonds for private hospitals. This problem could be resolved by delaying the effective date of such provisions. This would allow States to reconsider existing prohibitions and, if they choose, to modify such prohibitions.

Copies of this paper ("Tax Subsidies for Medical Care: Current Policies and Possible Alternatives," January, 1980) are available free of charge from the Congressional Budget Office, 2nd and D Streets, SW, Washington, DC 20515, or by calling 202-225-4416.

Drug Product Selection

Prescription drugs cost American consumers more than $8 billion in 1977. In addition, persons over age 65, although only 11 percent of the population, pay 25 percent of the national drug bill, often from limited incomes.

In 1976, the Federal Trade Commission (FTC) opened an investigation on the sale of multisource prescription drugs to find out: whether price competition for multisource prescription drugs is unduly restricted by State antisubstitution laws that prohibit pharmacists from selecting lower cost sources of drugs prescribed by brand name, and whether the FTC should attempt to remedy any existing problem.

Staff of the FTC Bureau of Consumer Protection (BCP) concluded that antisubstitution laws do impose substantial unwarranted costs on consumers by unduly restricting price competition in the multisource prescription drug market, and that the repeal of antisubstitution laws would produce significant consumer benefits without compromising the quality of health care.

FTC/BCP staff recommend that States adopt the joint FTC-HEW Model Drug Product Selection Act to remedy the situation, facilitating pharmacists' selection of drug products therapeutically equivalent to, but less expensive than, products prescribed by brand name. The model law is discussed later in this article.

The Problem: Patients have little or no influence on which drug products they will buy and what prices they must pay for such products. Physicians prescribing the drugs seldom are aware of drug prices, which often vary widely for different brands of a chemically equivalent drug. It is time consuming and, thus, costly for physicians to get comparative cost information on drugs they prescribe; in addition, their primary concerns with drugs they prescribe are relative performance, benefits, and risks.

Almost 90 percent of all prescriptions specify brand names, in part because brand names are generally shorter and easier to recall than generic names. Yet, quite often, several chemically identical products with different brand names are in fact made by one manufacturer and sold to pharmacists at varying prices.

During the patent period, when the manufacturer has exclusive production rights, a drug is usually sold under its brand name, which may become so closely associated with the drug in the minds of physicians that they continue to prescribe it long after expiration of the patent. This brand/drug association is also fostered through extensive promotional campaigns by the major drug companies. A 1977 FTC Bureau of Economics staff report found that in 1970, thirty of the largest prescription drug manufacturers spent $682 million on drug promotion—21 percent of the firms' total U.S. sales, or an expenditure of over $2,400 per practicing physician.

Under antisubstitution laws, if the physician prescribes a brand name, neither the pharmacist nor the patient can choose from among diversely priced equivalents. Thus, companies that succeed in familiarizing physicians with their brand name products are insulated from the competition of lower priced, generic equivalents.

Early antisubstitution laws were enacted to prohibit dispensing counterfeit drugs, similar to popular products in color, size, shape and sometimes packaging, but of unknown quality, content, and origin. However, the antisubstitution laws also prohibited dispensing a different brand than the one prescribed.

As new Federal controls virtually eliminated drug counterfeiting, States, in the 1960s and 1970s, began to question the appropriateness of restrictive antisubstitution laws. Forty States and the District of Columbia now have drug product selection laws which permit the pharmacist, unless otherwise directed by the physician or the patient, to select a lower cost generic equivalent for the brand name prescribed.

The Issues: In examining antisubstitution laws and deciding whether or not to endorse drug product selection, FTC staff considered (and discuss in this report) several important issues.

One group of issues involves drug quality—how well the Food and Drug Administration regulates drug quality, the extent to which drug

products with identical active ingredients provide equivalent therapy, and the question of potential quality differences between brand name and generic name products. Related to these concerns are the pharmacist's technical ability to select drug sources and the assurance of the physician's right to specify a particular brand when medically necessary.

A second group of issues involves economic concerns—the pharmacist's incentives to select low cost generic equivalents and the extent to which pharmacists actually do choose such products, the potential savings to consumers from drug product selection, and the actual savings passed on to consumers by pharmacists. Associated with these concerns are questions about the extent to which pharmacists' anxiety about potential lawsuits inhibits product selection, and the potential effect of increased selection of low cost generics on research and development by brand name manufacturers.

The Recommended Solution: FTC staff recommend that States adopt the Model Drug Product Selection Act, developed by that agency and HEW. This model combines a number of features from existing State laws, and permits, but does not require the pharmacist to select a lower cost chemically equivalent drug product. The drafters of the report believe that providing pharmacists an economic incentive to select low cost products makes a mandatory law unnecessary. Staff also believe that mandatory laws may be unworkable because pharmacists' resistance to government intrusion may produce low rates of product selection unless costly enforcement is undertaken.

The Model Drug Product Selection Act permits pharmacists to select a lower cost generic drug product from a 'positive formulary' of drugs that FDA has determined to be therapeutically equivalent; recognizes that physicians have absolute authority to prohibit drug product selection, based on their medical judgment; assures that pharmacists who choose lower cost generic drug products will share these savings with consumers, without eliminating incentives to dispense generic drug products; assures pharmacists that no greater liability is involved in generic drug product selection than in filling a generic prescription; and permits consumers to choose a less expensive generic drug product selected by the pharmacist or the prescribed brand name product.

A related article in *American Druggist* (June 1979) reported comments by Congress' only pharmacist, Rep. Mickey Leland (D-Texas), on drug product selection laws at the American Pharmaceutical Association (APhA) meeting. Rep. Leland disagreed with APhA opposition to the Federal drug product selection law introduced in the last session of Congress, but agreed with the APhA that "normally, regulation of professional practice may be left to the States," adding that "today we face a complex array of health problems, many of which can be addressed only by Federal action."

The same issue of *American Druggist* also reports that the 16,000 member American Society of Internal Medicine has adopted a policy statement which encourages physicians to prescribe generically "when therapeutic equivalency....is assured."

For information or copies of this publication ("Drug Production Selection, Staff Report to The Federal Trade Commission, January 1979) contact Dayle Berke, (202) 523-3389, Room 260, Federal Trade Commission, 6th Street and Pennsylvania Avenue, NW, Washington, DC 20580.

Medical Malpractice Claims

This synopsis, "Medical Malpractice Claims," covers a study conducted by the Public Health Service and the Health Care Financing Administration, in cooperation with the American Insurance Association. The study was conducted because of an earlier malpractice "crisis" (rapidly rising insurance costs and decreasing availability of medical malpractice insurance), and to obtain information about injuries which lead to malpractice claims. Some 4,000 closed insurance claims were analyzed during the course of study, representing about 28% of malpractice claims in 1976.

About half the claims studied resulted in awards averaging $27,000.[1] The researchers also found that most malpractice claims injuries occur in hospitals (about 78%). More than one third of successful claims against hospitals resulted from institutional factors (e.g., inappropriate treatment techniques, inadequate patient monitoring, patient falls, etc.). The study suggests that institution managers should concentrate surveillance and control efforts in two areas where

[1]The average award for all male claimants was about $10,000 higher than for female claimants, and the size of awards was found to decrease with age.

injuries occur, hospital operating rooms (42% of injuries) and patient rooms (24% of injuries).

To identify trends in medical malpractice insurance claims, this study's 1976 data was compared with similar 1970 data.[2] Not unexpectedly, the comparison revealed a large increase in the average award size, while the percentage of claims producing awards remained just over 45%. The award size increased by 94%, twice the general inflation rate of 47%.

Several legal issues were also explored. It was found that pretrial review panel[3] cases were more likely to go to court than nonreview panel cases. This might have resulted from selective use of panels in more complicated cases. Other findings revealed that six percent of the claims studied were settled by trial, 37% were settled without a suit being filed, and 53% of the cases in which a suit was filed were settled outside of court. Not unsurprisingly, it was found that multiple defendant cases take substantially longer to process, are more likely to go to suit and on to trial, and will produce a higher average award (almost four times higher). These findings may be due to the fact that cases with greater injury often involve more than one health care provider and more than one hospital injury. Multiple defendant cases are also more difficult to settle.

An attempt was made to determine whether malpractice awards adequately compensate for economic loss—lost present and future earnings, direct outlays, such as medical expenses and legal fees, actual damages, etc. Under the method used here, the average award was not found to be equal to the average loss. The study suggests that, if the finding that awards do not equal economic losses is accurate, a fairer award system would be periodic payments according to need rather than a single lump sum payment.

Medicare and Medicaid Findings: Medicare and Medicaid issues were also investigated during this study. It was found that Medicare pays "more than its fair share of malpractice insurance premiums" through that program's partial reimbursement of hospital administrative expenses (about 20%) and Medicare patients are more likely to be injured as a result of institutional errors. (They are more likely to fall and they are more likely to be injured in their own room.) The study suggests that injury prevention programs may be able to quickly change this trend.

Other study findings indicated that the average award to persons with private insurance and Worker's Compensation ($35,454) was three times larger than the average award to Medicare patients ($10,966) and about 25% of that for the average ($27,708) for all medical malpractice awards. One reason for the lower awards to Medicare patients: they are older than other patients and, therefore, their predicted lifetime earnings can be expected to be less. The only conclusion this study could reach on Medicaid cases was that they "do not distinguish themselves from the average of all payment sources."

The authors caution that broad conclusions about the nature and extent of malpractice cannot be drawn from this study because it deals only with information on closed malpractice claims during a part of one year. However, the study should be useful in identifying areas where injuries can be minimized or prevented.

Copies of this study ("Medical Malpractice Claims: A Synopsis of the HEW/Industry Study of Medical Malpractice Insurance Claims," HCFA-02108 1979, October 20, 1978) can be obtained from the Health Care Financing Administration, Office of Management and Budget, Office of Human Resources and Administrative Services, 1710 Gwynn Oak Avenue, Baltimore, Maryland 21235.

The PSRO and the Nursing Home

This two volume evaluation of Professional Standard Review Organization (PSRO) efforts in reviewing nursing home care given Medicaid and Medicare patients is recommended reading. The researchers conclude their study on an optimistic note: "The PSROs show great promise in the difficult task of further defining and monitoring the quality of nursing home care and ensuring that nursing home residents receive both humane and technically sound care."

This Health Care Financing Administration sponsored assessment was conducted by the Rand Corporation between October 1978 and August 1979, and retrospectively studied the operation of ten PSRO demonstration sites during the period October 1976 to September 1978. Volume 2 of the

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[2]U.S. Department of Health, Education, and Welfare, *Report of the Secretary's Commission on Medical Malpractice.* DHEW Pub. 05-73-88, January 16, 1973. U.S. Government Printing Office 1700 00114.

[3]This is a procedure which attempts to reduce the number of malpractice cases which go to trial. By the end of 1976, 27 States had adopted either a voluntary or mandatory form of this procedure designed to screen out non-meritorious cases and to promote settlement of meritorious ones.

report, *Ten Demonstration Projects in PSRO Long Term Care Review,* contains specific findings on each of ten PSRO long term care (LTC) projects and forms the basis for Volume 1 which summarizes these findings, and analyzes their significance for this review program

Researchers visited the ten PSRO demonstration sites several times, interviewing PSRO staff, committees and community contacts. Their methodology is thoroughly described in this report. Rand qualifies their findings by advising that only ten demonstration sites were surveyed, although more than 40 PSROs were doing LTC review. They further caution that theirs was a retrospective study and necessitated reconstructing data. Six major areas of PSRO LTC review were studied: preadmission review, admission review, continued stay review, concurrent quality assurance, medical care evaluation studies, and data collection and systems. These areas constitute a fully operational PSRO LTC review system. Each is thoroughly analyzed and summarized.

Preadmission Review (PAR): There were some significant conclusions regarding PAR, several of which merit serious consideration by Federal policymakers. First, survey results show that while Medicare days may be reduced by PAR, a significant number of denied patients still enter the LTC facility under private pay or Medicaid. Social and economic factors, while not considered under Medicare admission regulations, are nonetheless critical elements in determining LTC facility need. The authors are highly critical of the lack of criteria for level of care determination, and in fact, criticize this deficiency in all areas of review. The report recommends: 1) that more research be devoted to a PAR approach; and 2) that criteria and a reliable instrument for determining placement and level of care be developed.

Admission Review (AR): Rand concludes that AR is only relevant to patients who have not gone through the PAR process. They fault AR as a poor alternative to PAR because: it is more costly in terms of nursing home days expended while a decision is being made; it is more disruptive to a patient who is denied after admission; and it is more expensive to administer because, for post-hospital patients, it is conducted in each LTC facility rather than in the hospital. AR is really only viable for patients admitted from the community, the report concludes.

Continued Stay Review (CSR): The study noted great diversity among the ten sites in terms of criteria used to justify continued stay and the frequency of CSR. They credit some of the sites with attempting to make progress in this area. The report suggests that CSR be more focused and frequent on newly admitted patients, since experience shows that few patients in a LTC facility six or more months are reclassified or denied. The distinction, imposed by Federal law, between skilled nursing facility and intermediate care facility levels of care, impedes the natural movement of patients based on needs, and frequently forces a patient into a precise type of facility rather than the most appropriate, the report suggests. The authors point out that PSROs must "acknowledge the current need to admit or to retain in nursing homes, patients who might be more appropriately served by alternative community resources," because such resources are frequently not available.

Concurrent Quality Assurance (CQA): Researchers had a wide range of recommendations and conclusions in this area of review. They suggest that CQA include bedside assessment, in addition to review by a registered nurse (with no specialization required, such as geriatric nurse). Again, criteria development is cited as essential to this review area as with the others; further, drug criteria are needed and probably more easily developed than other types of criteria. Outcome criteria are also important to evaluate quality. The report recommends that peer review by professionals other than physicians (e.g., nurses, social workers, physical therapists, etc.) be increased. Researchers point out that most sites had not developed the capacity for feedback to determine whether their recommendations regarding quality of care were heeded. This, the study concludes, is an essential aspect of quality assurance.

Medical Care Evaluation Studies (MCES): Rand concludes that little substantive activity occurred in this area and recommends that MCE studies be an adjunct to concurrent quality assurance. Some of the barriers to effective MCES development were failure to develop meaningful process criteria and in-house disagreement about the nature of MCE studies. They suggest that this function may be more effective if not delegated back to the LTC facility with a cadre of professionals and experience that may be less than that of the PSRO.

Data Collection and Data Systems: Great variation in the amount and method of data collection (manual vs. automated) were identified in the study. The report recommends a serious national long range proposal for uniformity in data collection be developed because, "A nationwide PSRO data system, properly organized and supervised to assure sufficient data quality, would represent the single largest accumulation of data on nursing home patients available anywhere."

Conclusions: This comprehensive and insightful analysis of the PSRO LTC review program bodes well for the program's success, because progress has been made in an extremely complex area that attempts to fit genuine human needs into a structure of Federal, State, and local regulations and cost controls. The researchers' thorough and objective analysis offers substantive recommendations worthy of serious consideration.

Copies of The PSRO and the Nursing Home *can be obtained by contacting the Rand Corporation, Santa Monica, CA 90406, re. publication R-2459/1-HCFA.*

HMOs Evaluated

Viable, well managed Health Maintenance Organizations (HMOs) should need no more than $4 million (the amount specified by law) to cover operating losses, and should be able to achieve financial independence within five years after becoming qualified. This is the conclusion reached by the Comptroller General in a report to Congress (May, 1979), "Health Maintenance Organizations: Federal Financing is Adequate But HEW Must Continue Improving Program Management." The HMO Amendments of 1978 required the GAO to assess the adequacy of amounts of financial assistance under the HMO Act, as well as the adequacy and effectiveness of HEW's policies and procedures for managing the grant and loan programs.

GAO evaluated responses to questionnaires sent to 80 qualified HMOs, 80 HMO grantees, and 10 HMOs with grant or qualification applications in process as of September 20, 1978. In addition, GAO reviewed the Office of HMOs in Rockville, Md., and regional offices in Atlanta (Region IV), Chicago (Region V), and Denver (Region VIII). Also examined were financial data submitted to HEW by 42 HMOs (qualified by September 30, 1977).

Based on these evaluations, GAO observed that, "the key to financial success of an HMO is its ability to charge competitive subscriber rates which generate sufficient revenues per member to cover the costs of operation and provide sufficient additional funds to repay debts, replace facilities, and finance future growth." Generally, the HMOs studied were initially able to reduce average monthly costs per member as their membership reached 10,000. GAO explains that if this enrollment growth does not help lower average costs per member, enrollment growth will tend to increase the HMO's deficit and may exhaust Federal loan funds before the HMO can break even. So, HMOs need competitive subscriber rates that allow enrollment growth, yet are high enough to generate the per member revenues necessary to break even. GAO concluded that overemphasis on enrollment growth may hurt a developing HMO's chances for achieving financial independence. (This conclusion was supported by the experience of two HMOs that became insolvent.)

In light of this conclusion, GAO recommended that HEW assess HMOs' financial viability at appropriate points. Having secured certain financial data, HEW could encourage a new HMO to plan for only enough staff and facilities to enroll enough members to stabilize costs. At that point, per member costs may provide a baseline for projecting future costs. HEW could then determine whether the subscriber rates needed to achieve independence within five years will be competitive in the local market. This procedure would help minimize the government's risk of losses through loan defaults, GAO believes.

In response to earlier GAO recommendations, the Office of Health Maintenance Organizations had modified its loan administration; however, this report reveals that problems persist in issuing uniform policies for operating the deficit loan program, formulating regulations and policy guidance for the ambulatory health care facility loan program, and improving the staffing situation. In addition, GAO found the OHMO in need of a more effective monitoring program. Therefore, GAO recommended that: adequate staff should be assigned to OHMO to complete work on policies and regulations; required reports from qualified HMOs should be submitted more promptly; OHMO should assess the impact of the increasing number of qualified HMOs on its ability to monitor compliance, and promptly assign additional staff if required; and

priority should be given to validating HMO report data, completing a summary of compliance policy and procedures to assure uniformity, and rendering a decision on regional responsibilities.

The OHMO has concurred with these recommendations by placing priority on completing needed loan regulations, policies, and procedures, and filling certain needed positions. An effort will be taken to measure the impact of OHMO's new monitoring process and computer system on staff efficiency. Also, a structured policy and procedures manual will be produced, along with a decision on the future regional office role.

Finally, GAO recommended that OHMO develop guidelines for regional offices for improving their grant program. In response, OHMO is developing review standards for feasibility planning and initial development grants, and for monitoring during an HMO's initial development stage. Other efforts are underway to train regional personnel and grantees on management information systems, and to update a feasibility planning manual.

Copies of this report (HRD-79-72) are available from the U.S. General Accounting Office, Washington, D.C. 20548.

Recession's Impact on Medicaid and Health Coverage

Prompted by two conferences it sponsored on subjects related to the effects of inflation on the access, quality and quantity of health services to the disadvantaged, and the cost and incidence of catastrophic illness, NCHSR supported seven studies in these areas. The seven studies are capsulized in this report. They include: 1) an evaluation of the impact of adverse economic conditions on the health status of the poor; 2) utilization—the effects of unemployment and inflation on hospital-based ambulatory care; 3) impact of varying economic conditions on the use of community hospitals in Rhode Island; 4) access to ambulatory care and the U.S. economy; 5) health insurance loss due to unemployment—descriptive and behavioral analyses; 6) the impact of rising unemployment on the loss of job-related health insurance coverage; and, 7) public finance-impact of national economic conditions on health care of the poor.

Several articles examined the effects of the '74-75 recession on the ability of the unemployed to maintain health insurance. Researchers report that the period of unemployment is not usually the same as the period without health insurance, since employment provides health insurance for a prospective period. Therefore, workers who are unemployed for short periods may not be without health insurance at all. The eligibility requirements for health insurance are crucial to understanding the effect of the loss of health insurance. The authors report that during periods of unemployment, workers tend to require more health services and, in fact, have more health problems than when they are employed. While their needs and number of visits increased (to 34% more than employed persons) their access to physicians' services decreased.

The report examines the fiscal impact of the recession, and the resulting increased need for health services on the States. It appears that the ability of a State to handle the burden rests with the recession's impact on that particular State as well as the State's own economy and its ability to muster increased resources. Government programs have also had to assume an increased role in the provision of health care. One article suggests that a more responsive role for government would be to share with the unemployed worker the additional costs of maintaining health insurance. However, as one article points out, the great diversity among health insurance plans in terms of enrollment and benefits makes a simple solution, such as a government subsidy, very difficult. Another article implies that the more government provides, the more private job-related health insurance will diminish.

One article focuses on the effect of the recession on the Medicaid program which had an upsurge due to increased unemployment and inflation—the principal external force affecting Medicaid expenditures, according to the author. The program, even with its often criticized low reimbursement rates, has been unable to regulate total costs since providers can frequently compensate for reduced reimbursement by controlling the quantity of services provided. Medicaid costs change in relation to the number of recipients, number of services per recipient, variety of services provided, and the price of such services.

During the '74-75 recession and its accompanying high unemployment rate, States' Medicaid programs were severely fiscally affected. According to the author two major factors caused this stress: the increased demand for services, and the

formula for determining the State's share of payment. States' annual Federal medical assistance percentages (the percentage contributed by the Federal government towards Medicaid expenditures) are based on per capita incomes of several prior years. Thus, the percentage does not reflect the current stress of a recession. The author suggests a system which would reflect the States' current fiscal situations. Suggestions are also made for uniform eligibility criteria and a uniform and comprehensive service package. One of the most thought provoking recommendations in this article is a provision to exceed the regular Federal medical assistance percentage by an amount directly related to the State's unemployment rate. Several other suggestions for buffeting the Medicaid program against severe fiscal strain are provided.

"Effects of Recession on Health Care for the Disadvantaged," National Center for Health Services Research, Public Health Service, Publication No. (PHS) 79-3248, January 1980, may be obtained by contacting NCHSR.

annotated bibliography

"Comparison of Physician Charges and Allowances under Private Health Insurance Plans and Medicare," United States General Accounting Office, HRD-79-111, September 6, 1979.

At Congressional request, the U.S. General Accounting Office (GAO) compared physicians' charges to amounts allowed as reasonable under private health insurance plans and under Medicare. These comparisons were made at six plans (four commercial and two Blue Shield) operated by contractors (carriers) that also pay Medicare claims. The request was initiated because of Congressional concern "about the steady increase in the number of unassigned claims for physicians' services under Part B of the Medicare program, since on such claims the difference between the physician's charge and the amount determined by Medicare to be reasonable becomes a liability of the beneficiary." GAO reported that in 1978, about 71 percent of Medicare Part B claims had reasonable charge reductions and about 49.4 percent of Medicare claims for physicians' services were unassigned. These reductions created an additional beneficiary responsibility, on top of the required 20 percent coinsurance, of about 19 percent of submitted physicians' charges.

Reimbursement for physician services under Medicare is based on the "reasonable charge," determined by each carrier for its area of jurisdiction. The reasonable charge is the lowest of three charges or screens: the actual charge, the physician's customary charge, or the prevailing charge. The actual is the charge that the physician bills for the service; customary is the charge the physician usually bills most patients for the same service, and prevailing is the lowest charge high enough to include at least three-fourths of the bills for the same service billed by all the physicians in the same area. (Since 1972, the prevailing charge has not been permitted to increase more than inflation in general. This limit, called the "economic index," determines how much the prevailing may increase above 1973 levels.) The Medicare law also requires that the reasonable charge cannot be higher "than the charge applicable for a comparable service under comparable circumstances, to the policyholders and subscribers of the carrier..." GAO found the comparability comparison was a potential fourth charge or screen for determining reasonable charge.

Some of the GAO findings were: physicians were allowed over 10 percent more by private plans than by Medicare in 82 percent of the cases sampled; the four commercial carriers surveyed made reasonable charge reductions in 0 to 7 percent of the private claims reviewed, while the two Blue Shield carriers made reductions in 27 to 56 percent of their private claims; as Medicare carriers, all six carriers made reductions in 64 to 83 percent of the Medicare claims sampled.

GAO did not question the amounts allowed as reasonable by the six carriers under either Medicare or the private plans. However, the comparability comparison required by the Medicare law was found ineffective. GAO concluded that while the apparent intent of the provision was to limit or reduce program costs, neither the law nor HEW's regulations define comparability. GAO also found that

Medicare delegates responsibility for determining comparability to its regional offices, but does not know how many of the carriers have private plans that are considered comparable. In addition, no statistics were available to show that any Medicare claims were reduced, or that program limitations or savings occurred, due to consideration of comparability. Of the six plans reviewed for this study, only one private plan was considered by the regional office as comparable to Medicare. In practice, no situation was found where reduction of the Medicare allowed charge was necessary because of a lower comparable screen.

The only GAO suggestion resulting from this sample study was that Congress should consider either deleting the comparability language from the law or defining comparability "so that any private plan which intends to reimburse. . . on the basis of a current 'reasonable charge' is considered comparable to Medicare." GAO concluded that because of significant and basic differences between Medicare and private health insurance plans, deletion of the "comparability" language was preferable. Deletion of this language "would have little, if any, financial effect on Medicare and would alleviate an ineffective program requirement" and the associated administrative costs. (Single copies of the report are available without charge from: U.S. General Accounting Office, Distribution Section, Room 1518, 441 G Street, N.W., Washington, D.C. 20548.)

"Interim Report of the Graduate Medical Education National Advisory Committee to the Secretary," Public Health Service, Health Resources Administration, HEW Publication No. HRA 79-633, April 1979.

Although the number of physicians in the U.S. now appears to be adequate, the national distribution of physicians by type remains a problem because it prevents equitable access to physician services by large segments of the population. This committee was appointed to advise, consult with, and make recommendations to the HEW Secretary regarding the number of physicians needed in the U.S., their specialty and geographic distribution, ways to effect a more desirable geographic distribution of physicians, and methods to finance graduate medical education. This report lists preliminary assumptions and findings, and outlines the scope of the final report.

The report discusses, among other things, the past and present status of graduate medical education in the U.S., current physician education, specialty and geographic distribution, including the supply of female and minority physicians and foreign medical graduates, and makes projections into 1990 concerning physician supply and distribution. The report indicates the supply of physicians will continue to grow, as will the ratio of physicians to population. It also includes several sections dealing with nonphysician health care providers and alternative methods of financing graduate medical education which could influence physician distribution.

Copies are available from the Public Health Service, Health Resources Administration, Paul Schwab, Executive Secretary of the Graduate Medical Education National Advisory Committee, 3700 East-West Highway, Room 1027, Hyattsville, Maryland 20782.

"Responses of Canadian Physicians to the Introduction of Universal Medical Care Insurance," National Center for Health Services Research, *Research Digest Series,* HEW Publication No. PHS 80-3229, February 1980.

This study, covering the period 1971-1975, was designed to determine the effects of universal and comprehensive medical care insurance on physician location, distribution, practice patterns, mobility, cost of services, etc., in the province of Quebec. Analysis of the study provides insight into policy options for the U.S. on influencing physician distribution and the design of an effective National Health Insurance plan.

The researchers found the ratio of active physicians to population in Quebec increased at a rate seven times the comparable growth rate in the U.S., leading to an increase in the use of physician services, even though the average gross payment per physician remained constant. However, this did not appear to affect the uneven geographic distribution of physicians. Marked differences between

Quebec and the U.S. General Practitioner (GP) medical practices were found. Quebec GPs employed about a third as many aides as U.S. GPs, although Quebec GPs worked about as many hours as U.S. GPs. Canadian GPs spend more time per patient visit in their offices, so they see only about 60% as many patients as U.S. GPs, and the average wait for a GP appointment exceeds the U.S. figure by 60 to 100%. More Quebec GPs belong to group medical practices than their U.S. counterparts.

This study also found the Quebec Medicare system allowed reasonably uniform access to medical care across income and location groups, even though medical specialists were less evenly distributed than GPs. A substantial shift from ordinary office examinations to the more expensive complete and major examinations was also observed. The movement of GPs to high payment areas suggests financial incentives as policy options which could affect physician distribution. The study concludes that useful insights can be drawn from analysis of operational data produced under a fee-for-service national health insurance system.

Copies are available from NCHSR, Publications and Information Branch, 3700 East-West Highway, Room 7-44, Hyattsville, Maryland 20782.

Behn, Robert D., Sperduto, Kim, "Medical Schools and the Entitlement Ethic," *Public Interest*, No. 57, Fall 1979, pages 48-68.

In the 1960's, efforts to increase the number of physicians nationwide led to Federal legislation authorizing grants to medical schools. In this article, the authors examine why the capitation grant program was not terminated when the legislation expired in 1974, even though it had reached its objectives—medical school enrollment increased rapidly, and the physician shortage disappeared.

Among the arguments that emerged for continuing the grants was a perceived Federal responsibility to provide health care to the public through a continuing supply of physicians. Also, by funding nearly 50% of medical school revenues through research contracts, health-manpower training programs, and Medicare and Medicaid, the government had created financial dependency. Thus, the entitlement ethic: "Once the government establishes a program, those who receive benefits from that program believe they are entitled to them." This logic appeals to our compassion, the authors contend, since the question becomes not whether the program should be ended, but whether certain individuals should lose their benefits.

A preferred alternative to terminating the program came from "activists" who recognized the maldistribution of physicians by specialty and geographical location. Through modifying the capitation grant program, they believed choices of medical students could be influenced, and the maldistribution problem would improve. According to the authors, "If the government was going to pay to sustain the medical schools and educate students, it was also going to extract some conditions." Hence, rather than capitation grants being terminated, the program was modified to address the issue of maldistribution.

Davidson, Lynne R., "Choice by Constraint, The Selection and Function of Specialties Among Women Physicians-in-Training," *Journal of Health Politics, Policy and Law*, Vol. 4, No. 2, Summer 1979, pages 200-215.

Few studies have focused on women in the medical profession. Here, the author explores reasons for selection and the function of specialties for women physicians, during their years between internship and residency. The author cites primary reasons why women physicians cluster in certain specialties, and relates these reasons to findings from a survey of men and women interns and residents, conducted through intensive interviews and self-administered questionnaires. Statistical tables from the survey are included.

One reason for selecting specialties is offered in sociological literature: sex role compatibility—pediatrics, psychiatry, obstetrics and gynecology, and public health function to reduce conflict between the traditional sex role and the medical professional role. Davidson argues that this logic only serves to remind women that there are a *few* places in medicine, but not too *many*, and thus

imposes a choice by constraint. A second explanation is offered—that women select specialties that are the least time demanding and have regular hours. Indeed, the author asserts, this represents another compromise or choice by constraint.

Davidson's survey reveals that both men and women consider their primary reason for choice of specialty is pursuit of intellectual interest. Women, however, are compelled to choose specialties within their fields of interest, "that offer them the greatest availability of hospital and institutional positions followed by a subspecialty, *within* the specialty, that allows for limited working hours." The survey also indicates cultural values and personal experiences have encouraged women to adopt "traits of affectivity" (e.g., nurturance or sympathy) contradictory to the ones valued by the traditional medical profession, and usually male stereotyped (e.g., detachment or over-rationality).

In conclusion, the selection of medical specialty by women physicians-in-training is based on the interactive effect of many subjective and objective constraints. She states, "These constraints can change to the extent that women enter the system actively determined to restructure it. In part...by heightening their own consciousness and strengthening alliances with other groups also demanding change..." To illustrate the dominance of male ideology in the medical profession, Davidson cites the title of a conference which was specifically designed to increase opportunities for women physicians: "Meeting Medical Manpower Needs." Furthermore, a main proposal of the conference was, "...the encouragement of women to train especially for *scheduled* specialties."

Burney, Ira L., *et al.* "Medicare and Medicaid Physician Payment Incentives," *Health Care Financing Review*, HEW, Health Care Financing Administration, HCFA Pub. No. 030028-79, Summer 1979, pages 62-73.

Using Medicaid and Medicare payment data, the authors analyzed the effect of various types of Medicaid and Medicare physician reimbursement on six interrelated aspects of health care costs and access to care. Medicaid and Medicare data were used for the study because: the programs account for over one-fifth of physician spending; data on reimbursement methods, rates, and administration are available; and Medicare reimbursement presumably reflects private sector payment patterns. The six interrelated aspects examined in the study were: physician reimbursement and inflation, physician participation, geographic and specialty distribution, place of treatment, and type of service rendered. The study led the authors to several interesting hypotheses.

First, they suggest that the widely used CPR (customary, prevailing, and reasonable charge) method of reimbursement may be more inflationary than fee schedules. Second, analysis showed a direct relationship between reimbursement policies and physicians' participation in both programs. Medicare beneficiaries have about the same access to health care as privately insured persons; however, Medicaid patients are at a disadvantage. This is likely due to the low fees which discourage physicians from accepting Medicaid patients. In fact, the authors claim, "Medicaid fees average about 75 to 80 percent of Medicare and Blue Shield fees and about 60 percent of physicians usual fees." The study further suggests that reimbursement policies affect geographic and specialty distribution, by encouraging physicians to locate in higher reimbursement areas.

The authors cite criticism against the current reimbursement system, which pays more for services performed in hospitals than in offices. This provides an incentive for physicians to use more costly inpatient care and to perform more surgical rather than medical procedures.

The authors conclude that the current reimbursement system must be modified before national health insurance.

Copies of the *HCFA Review* are available from HCFA/ORDS, Baltimore, Maryland 21235.

"Drug Therapy and the Aged," American Pharmaceutical Association, Reprinted from *American Pharmacy*, Vol. NS18, No. 7, July 1978, pages 346-359.

This special section includes several separate articles—all relating to the issue of drug therapy for the nation's 23 million elderly citizens. Each article focuses on a slightly different aspect of the issue, but, collectively, they form a strong argument for action—social, regulatory, and economic.

The first article discusses the role of the skilled nursing facility consultant pharmacist, a role that, the author claims, has shifted from drug dispenser to consultant and monitor. An interesting history of the development of this role is discussed and the effect on cost and quality control is highlighted.

Another article asks whether drug therapy for the elderly is all it could be. Examples of inaccurate diagnoses for elderly institutionalized patients are cited as well as the fact that 95% of these patients are taking prescription drugs. The vulnerability of the aged to drug related problems, including: improper or inappropriate utilization; improper patient self-administration; and, risk of drug reaction and interaction, all strengthen the rationale for an increased role for the pharmacist. The author suggests that pharmacist specialization in the long term care area would enhance capabilities to fill such a critical need.

Another article makes a strong case for a national drug benefit program for the elderly and cites many socioeconomic reasons to support such a program. The author wants a program that is, "at a price that is fair, just and equitable to providers, taxpayers and recipients alike."

The often overlooked relationship of drug therapy and nutrition is the subject of another article. Not only can drugs interfere with nutritional status, but food can alter the speed of desired drug reaction or the reaction itself. Since the elderly are susceptible to more variation in drug administration than other age groups, the author stresses that factors increasing the predictability of drug response be studied.

"State Policies on Unit Dose in Long Term Care," American Society of Consultant Pharmacists, 1979.

Due to an increasing interest in unit dose dispensing systems in nursing homes, the American Society of Consultant Pharmacists conducted a survey of State policies on unit dose in long term care facilities. ("Unit dose distribition entails packaging and labeling individual doses of medication in containers so that the identity and integrity of the drug product is maintained from the point of packaging to patient consumption.")

Included in this report is an analysis of the data obtained from responses to 125 questionnaires sent to Medicaid agencies, pharmacy boards, and pharmacy associations in all States.

Results indicate that twelve State Medicaid programs have reimbursement formulas that pay pharmacists using a unit dose system in nursing homes a higher fee than that paid for prescriptions dispensed via traditional methods. Also, some 22 States have regulations or guidelines specifically to cover unit dose, with eleven States currently planning to adopt such regulations or guidelines.

To obtain a copy of this report write to: American Society of Consultant Pharmacists, 2300 Ninth Street South, Arlington, Virginia 22204, or call (703) 920-8492.

Trapnell, Gordon R., F.S.A., "The Cost of a National Prescription Program," *National Health Insurance Issues*, Roche Laboratories, 1979.

This report examines the cost and policy implications of a national prescription drug program. Essential factors in such evaluation, the author states, are: who uses prescription drugs; what do they spend; which groups of people (by age and income) require the most protection; what would a program cost; and what would be the source of its funds. There are many possible plans, all with different costs and coverage, based on what is provided to whom.

The author examines the various plans ranging from one which would provide only maintenance drugs with a $2.00 copayment by the aged and chronically disabled, to one which would make all

drugs available with a $2.00 copayment by the entire population. Projected 1983 total national spending would be $6.9 billion and $24.9 billion, respectively, for these programs, Trapnell estimates.

Eight alternative national prescription programs are analyzed in the report using the following factors: 1) population groups—only the aged and disabled or the entire population; 2) services covered—only maintenance drugs or all legend drugs and insulin; and 3) cost sharing provision—$2.00 copayment, $50 annual deductible and 20 percent coinsurance, or family deductible of 2 percent of annual income. The author identifies and discusses many of the national drug bills introduced in Congress which are examples of his eight alternatives. Features of each are examined and compared.

This report provides interesting comparison and analysis of possible national drug programs, and examines the important implications regarding who is covered, what is provided, what it would cost, as well as who might be responsible for the additional finances required.

"Simplifying the Medicare/Medicaid Buy-in Program Would Reduce Improper State Claims of Federal Funds," United States General Accounting Office, HRD-79-96, October 2, 1979.

GAO initiated this review to determine the accuracy of States' claims for Federal sharing in the Medicaid program, specifically the buy-in aspects of that program. States design and operate their own Medicaid programs, which pay for medical services provided to eligible low income persons. Those who receive cash assistance under Aid to Families with Dependent Children (AFDC) are automatically eligible for Medicaid. The design of a State's Medicaid program may provide eligibility for aged, blind, or disabled people who receive cash assistance under the Supplemental Security Income (SSI) program or under State mandatory or optional SSI supplemental programs. In addition, a State program may provide Medicaid eligibility for those whose income or resources, while precluding cash assistance, are sufficiently limited to need assistance with medical costs. The Federal government shares the cost of medical services with the State, with sharing based on a State's per capita income and the Federal share ranging from 50 to 78 percent.

An individual eligible for Medicaid may also be eligible for Medicare Part B, a Federal program which pays for certain medical and physician services. The monthly premium for Part B ($8.70 effective 7/79; $9.60 effective 7/80) may be paid by the State, permitting transfer of some medical costs to the Federally financed Medicare program. The State may elect to buy in for cash recipients only or for cash and noncash recipients. (Five States with Medicaid programs do not have a buy-in program.) The Federal government will share half of the Part B premium cost if the individual is a cash recipient or considered a "cash recipient for buy-in purposes" (a special protective category for those who have lost cash status because of legislation which increased benefit, therefore income, level). The buy-in provisions prohibit States from claiming Federal sharing on medical services costs covered by Medicare but paid by Medicaid for recipients eligible for but not enrolled in Medicare Part B.

GAO reviews were made in ten States: four without buy-in programs, three which buy in for cash assistance recipients only, and three which buy in cash and noncash recipients. The essential finding was "complying with the requirements for claiming Federal Medicaid sharing related to Medicare/Medicaid eligibles is difficult."

Of the States reviewed, all except one improperly claimed Federal sharing, either over or underclaiming. Problems experienced by the States included an inability to accurately identify recipients eligible for Medicare Part B (i.e., dual eligibles), inadequate procedures for tracking medical services to be excluded from Federal sharing, and an inability to identify "cash recipients for buy-in purposes."

GAO proposed a variety of legislative changes which might be considered to simplify buy-in program administration and potentially reduce States' improper claims for Federal sharing. Three

of the proposals were: require States to buy in all dual eligibles and permit Federal sharing in all premium payments; require buy-in for dual eligibles but prohibit Federal sharing in premium payments; require States to buy in cash recipients, prohibit buying in noncash recipients and share in all medical payments for noncash recipients.

GAO recommended that whether or not there was legislative change, HEW should more closely monitor States' administration of the program, collect funds overclaimed by States and reimburse underclaiming States, and provide more assistance to States with buy-in programs.

States commenting on the legislative proposals favored an expansion of Federal sharing in the buy-in program. HEW agreed with GAO findings, indicated actions were underway or planned to implement the corrective recommendations, and stated that legislative options were being analyzed. (Single copies of the report are available without charge from: U.S. General Accounting Office, Distribution Section, Room 1518, 441 G Street, N.W., Washington, D.C. 20548.)

"Indirect Costs of Health Research—How They are Computed, What Actions are Needed," United States General Accounting Office, HRD-79-67, July 27, 1979.

This report concerns the system used to compute indirect costs of health research under Federal government grants and contracts, and discusses why such costs are rapidly increasing. "Indirect costs" is an accounting term used to describe the costs of goods and services (i.e., general administration, building and equipment charges), which cannot be readily attributed to a specific project. This study explains why there cannot be a meaningful comparison of indirect cost rates among research grantees and demonstrates the inconsistencies in principles and practices used to make such indirect cost rate determinations.

Although the Federal government does not reimburse grantees 100 percent for research project costs, there is no limit to the government's reimbursement of indirect research costs. These costs are assuming a larger proportion of each research dollar.

The report indicates that various factors, such as age and type of facilities used, accounting system differences, and type of research performed, cause wide variations in indirect cost rates. In addition, GAO points out that there is no one single set of Federal guidelines setting forth cost principles, required audit frequencies, or instructions to Federal staff regarding negotiation of indirect cost rates.

GAO concludes that certain actions are needed to make indirect costs principles more consistent, and audit staffs should be used more effectively in verifying research grantee's data offered during indirect cost rate negotiations. Finally, if Federal participation in health research costs is to be limited, the report recommends this be done through a formal ceiling on Federal reimbursement, one requiring minimum mandatory grantee participation in total costs, rather than one limiting government reimbursement of indirect research costs.

Single copies of this publication are available on request from the General Accounting Office, Distribution Section, Room 1518, 441 G Street, N.W., Washington, D.C. 20548.

Simler, Sheila L., "HCFA Programmed to Pay Out Less," and "Proliferating Regs will Tighten Reimbursement," *Modern Healthcare*, February 1980, pages 48-52.

In an interview with the author, former HCFA Administrator Leonard D. Schaeffer stresses HCFA's long range goal: to have a case-mix related reimbursement system. HCFA is considering many case-mix techniques including diagnostic related groupings (a classification system of 383 patient diagnoses), while various case-mix demonstration projects are underway. HCFA is seeking a method for paying appropriate costs for beneficiary services that is acceptable industrywide. Schaeffer explains HCFA wants a uniform coding system to identify procedures nationwide, and favors CPT-4 (a physician's procedural coding system) as the basis for such a system. He adds that a uniform diagnostic coding system will be based on ICD-9-CM, an international classification of

diseases. HCFA's Annual Hospital Report (AHR), formerly called the System for Hospital Uniform Reporting (SHUR), awaits a second comment period and Congressional approval before implementation. (The AHR would establish a uniform method for hospitals to report the cost and volume of Medicare and Medicaid services.) This modified proposal will eliminate eight of the 12 uniform reporting forms, among about a dozen other changes.

In a following article, Ms. Simler summarizes several upcoming HCFA regulations which should tighten reimbursement. For example: 1) the definition of special care units will be limited to those comparable to intensive care units; 2) more items and services will be added to those that are subject to "lowest charge" criteria; and 3) procedures for calculating costs allowable for education programs will be proposed.

Copies of the reprint containing these articles are available through HCFA's Medicaid/Medicare Management Institute Clearinghouse, 389 East Highrise, Baltimore, Maryland 21235. To order by telephone call (301)-594-8856.

Health Services Policy Session, Federal Trade Commission, June 1979.

The FTC Office of Policy Planning and Evaluation prepared this briefing book for the Commission's Policy Review Session on Health Services in June, 1979. The report indicates that, "health care is the largest single component of the service sector in our economy, representing 32.5 percent of all services in 1977." FTC staff report that the health care industry is the third largest employer, after agriculture and construction. The authors begin by describing the general characteristics of the industry in terms of economics and components, i.e., providers. The various factors which influence the continued rise in health care costs are examined, including the shift to institutional over ambulatory care, increased complexity of services, and the increase of the elderly population. Other factors affecting costs are methods of financing. Several alternative financing mechanisms such as prepaid group practices and individual practice associations are discussed; supporters argue that these alternatives can substantially reduce health care costs. The report also profiles the various types of health professionals in terms of their numbers, qualifications, role in health care delivery, and most interestingly, how alternative use of certain professionals might influence health care costs.

The Commission is involved in several areas of health care delivery: health care financing and alternative delivery systems, staffing, long term care institutions, and others. The Commission's activities and influence in each area are covered as are the various areas of public policy in which the Commission may become involved, such as inflation in prices and expenditures, hospital and other health care facility issues, and consumers' access to information. FTC staff suggest that the Commission may focus on such areas as hospital practices, entry restrictions on alternative providers, measure to increase consumer information, and the insurance market and tax reform.

Zelten, Robert A., "Consequences of Increased Third Party Payments for Health Care Services," *The Annals of the American Academy of Political and Social Science,* Vol. 443, May 1979, pages 25-40.

The author briefly describes the evolution of third party health insurance programs in the U.S.: Blue Cross and Shield, commercial health insurance, Federal Employees Health Benefits Program (FEHBP), health maintenance organizations (HMOs), Medicare, and Medicaid. He finds that these programs are uncoordinated, sometimes work against each other, and have produced a multiplicity of reimbursement arrangements.

The article discloses that in the past 35 years, health care has more than doubled its share of the gross national product (GNP). Various tables from HEW's July 1978 *Social Security Bulletin* are provided, revealing that in fiscal year 1977, almost 70 percent of all personal health care expenditures came from third party payment programs, 40 percent from public and 28 percent from private third parties. These tables also show that 94 percent of the dollars to hospitals are provided by third party

payments. The author finds that "until it can be demonstrated that the increasing sums spent for personal health care services are generating equal improvements in health status, there will be continued pressure to contain the dollars flowing to health care."

The author links the coverage provisions in most health insurance contracts and the reimbursement levels to the shortage of primary care physicians, those who can most effectively guide the patient through the complicated health care system. He also finds the mechanics of some widely used reimbursement methods provide strong incentive for physicians to increase their usual fees to the maximum customary limit allowed. He ties the oversupply of hospital beds to the better health care coverage for inpatient treatment rather than less expensive outpatient services. He suggests that the "growing complexity of the 'system' of paying for personal health care services helps to reveal the difficulty of developing a national policy that might be able to control the escalation of health care costs."

The author concludes that insurance has played a role in the tremendous expansion of national health care expenditures and that "...some believe that the country's health care cost problem is due to too much insurance coverage...and more coverage will simply exacerbate the cost problem." He believes the future of third party programs depends on their ability to address the negative consequences he has identified.

Selim, Robert, "Health in the Future: In the Pink or in the Red?" *The Futurist,* October 1979, page 329.

Increase in life expectancy illustrates the strides the U.S. has taken in the twentieth century to improve health care and medicine. Despite medical care advancements, the American people are dissatisfied. They complain about the shortage of doctors, impersonal care, and exorbitant health care costs. In this article, the author discusses the health care delivery system in the U.S. today, its pluses and minuses, makes predictions, and gives suggestions on the health care system of the future. He points out that social and environmental problems such as poverty, poor sanitation, pollution, ignorance, unsafe working conditions, malnutrition, and bad health habits contribute to poor health in Americans, and that these problems must be dealt with. He asserts that good health is not only the responsibility of health care providers, but of individuals and society as a whole.

He discusses reasons why health care costs are kept high and emphasizes that the future of medicine and health may have to include de-emphasizing "most-favored diseases" and spreading health care dollars more evenly. Also discussed are various health care options; he briefly outlines Sweden's organization for hospital care, and points out possible ways to address physician shortages by expanding roles for nurses and physician assistants. The use of computers and telecommunications in health care delivery is also addressed.

Included is a decade-by-decade forecast of possible medical advances for the 1980's, 1990's, and beyond 2000.

Luft, Harold S., Frisvold, Gary A., "Decisionmaking in Regional Health Planning Agencies," *Journal of Health Politics, Policy and Law,* Vol. 4, No. 2, Summer 1979, pages 250-272.

In the current medical care environment emphasizing cost containment through planning and regulation, the certificate of need program serves as a cost control tool for participating Health Systems Agencies (HSAs), established by the National Health Planning and Resources Development Act of 1974. This article focuses on the certificate of need decisionmaking process. First, the authors discuss similarities and differences between HSAs and their predecessors, Comprehensive Health Planning (CHP) agencies. Then, by examining the certificate of need review process in two California CHPs, they anticipate how HSAs are likely to perform. Finally, the authors offer suggestions to improve regional health planning decisionmaking.

To provide a framework for analyzing the two CHPs, the authors present a descriptive model of the certificate of need review process. The model outlines three conditions for a proposal to be approved:

1) need for the proposed project is justified; 2) the project is not shown to be infeasible; and 3) a better alternative project is not found.

One striking feature in the analysis is that most projects were approved without seeking better alternatives. This, the authors explain, may be due to limited staff ability to generate alternatives—staff can only suggest projects to providers, not create them. Also, it appears that tradeoffs between need and cost are avoided. For example, a hospital adding beds may be able to offer more services than a new hospital, but the new facility may have a better location. In this case, more data would be needed than is currently available. Further, the authors state, "larger professional staffs of HSAs may be able to collect additional data, but it will still be technically and politically difficult to erect a set of value-based tradeoffs to underpin choices among alternatives." In conclusion, the study suggests two approaches to improve regional health planning decisionmaking: 1)identified needs can be better met either by increasing the agency's ability to generate alternatives or by encouraging facilities to submit competing applications; and 2) a regional health care budget could force the agency to make choices among competing needs.

Hawkins, Sue C., and Rigby, Donald E., "Effect of SSI on Medicaid Caseloads and Expenditures," *Social Security Bulletin*, Vol. 42, No. 2, February 1979, pages 3-14.

The Federal supplemental security income (SSI-Title XVI of the Social Security Act) program, created by the 1972 Social Security Amendments to replace Federal-State public assistance programs for the needy, aged, blind, and disabled, changed the automatic Medicaid eligibility provision for cash assistance recipients under Title XIX (Medicaid) of the Act. Before January 1, 1974, anyone receiving money payments under the Federal grants-in-aid programs was automatically entitled to State medical assistance.

This study discusses changes in State Medicaid caseloads and payments following the implementation of SSI, the effects SSI has had on such changes, and also includes a short discussion concerning the effects that changes in the Medicare program have had on Medicaid expenditures. Most of the data in this article covers the five year period January 1971-December 1975.

Prior to the implementation of SSI, Congress and various State government agencies expected SSI would greatly increase (possibly double) the number of people eligible for Medicaid, and the amount of such expenditures. Although Medicaid expenditures and the number of cash assistance recipients increased under SSI, the authors found that SSI did not significantly affect these changes. The study indicates that the main reasons for the growth of Medicaid payments was the expansion of medical services to include care in intermediate care facilities, inflation, and higher utilization of medical services.

Copies of the Social Security Bulletin are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Schwartz, Jerome L., "Strategies for Monitoring the Effects of Proposition 13 on Health Services," *Journal of Health Politics, Policy and Law*, Vol. 4, No. 2, Summer 1979, pages 142-154.

In a time when "the 'tax revolt' may become a leading national issue," California's experience with Proposition 13 should be of interest to health care administrators nationwide. The passage of Proposition 13 in California resulted in a reduction of funds for local programs. In this position paper, the author presents background on the origins of Proposition 13, and looks at short range and potential effects on publically funded health services. He stresses the importance of monitoring to determine 13-type effects on public and private health services in such areas as access to health care, costs and quality of care provided. Specific strategies for monitoring are outlined.

Schwartz identifies 17 areas to be carefully monitored, including: finances—from county budgets; health personnel staffing; services available; recipients; effect on Medi-Cal; health status indicators (e.g., does a reduction in preventive services increase costs under Medi-Cal?) and health policy issues (e.g., how do local agencies decide which services to cut or reduce?).

Schwartz suggests these data monitoring techniques: conducting surveys of county health programs; using existing data collected by counties and reported to the State (e.g., Medi-Cal data can provide information on eligibility and physician participation); and creating data sources (e.g., a telephone hotline or public meetings). In addition, a County Health Information System should be developed to coordinate data collecting, analyzing and reporting.

Although it is early to judge Proposition 13 effects on county health services, some trends are emerging: personnel shortages (due to wage freezes); service reductions (e.g., in emergency care, preventive services, long term care); and terminated contracts with community clinics (jeopardizing access of poor people to primary care), among others. Schwartz believes, "the most telling effects of Proposition 13-caused deterioration of our programs is likely to be the decline of the quality of life and health of the population."

Mississippi Medicaid Commission Tenth Annual Report, July 1, 1978-June 30, 1979, Mississippi Medicaid Commission, November 1979.

This annual report was prepared by the Medicaid Commission for their State legislature. It contains data on all aspects of the Medicaid program including: coverage, administration, expenditures, and services. Numerous charts are used to illustrate data and interesting narrative summaries accompany each section.

The Commission reports that the average monthly number of eligible persons during FY 79 was 285,112, with an increase of about 15,000 from the beginning to the end of the fiscal year. The report indicates that the utilization rate ranged between 45.7% and 54.4% during FY 79, with an average of 49.8%. The range of utilization rates by program category was: 73.6% aged; 57.4% blind; 74.6% disabled; 31.7% AFDC children, and 50.0% AFDC adults.

Mississippi's Federal Medical Assistance Percentage (FMAP = percent at which the Federal government matches State Medicaid expenditures for health care) is 78.09, but because other costs are matched under different percentages, the report compiles an overall State percentage contribution of 23.25% with the Federal government matching at 76.75%. The Commission further provides expenditure data totalling $198 million and illustrates expenditures by types of service provided and category of user.

The report concludes by identifying all State hospital and nursing home providers receiving Medicaid payments exceeding $25,000 and all other providers receiving over $10,000. This report interestingly and illustratively explains the Mississippi Medicaid program. Its additional value is that it reflects a well organized and carefully planned State effort at explaining its Medicaid program. Other States may benefit from the style, format and readability of this report.

Lewis, Richard, "Oregon County Buying Prepaid Care for Needy," *American Medical News,* July 27, 1979.

Project Health is an "insurance broker" for 6,300 Multnomah County (Portland, Oregon) residents who earn too much to qualify for Medicaid, too little to afford quality medical care on their own, and are not covered by employer health benefits. Described as a unique experiment in alternative health care for the poor, Project Health offers its clients a choice of six private prepaid health plans, and subsidizes the premiums from a pool of county, State, and Federal funds. Project Health was created in 1974 largely through efforts by county executive Donald E. Clark to redirect county funds from Multnomah County Hospital. Soon to be expanded to include Medicaid, Project Health could serve as a prototype for national health insurance, according to Clark, "but you would have to build a capability for delivering services in rural areas." Some 80% of the clients choose one of the prepaid plans, but for the 20% unwilling or unable to enroll in any of the plans, Project Health maintains contracts with physicians and hospitals to provide limited service on an as needed basis. Clients receive counselling about each of the competing plans.

One of the project's goals is cost containment, according to Director W.T. Johnson. He adds that using private sector concepts such as risk sharing, competitive pricing, and consumer cost participation is expected to save taxpayer dollars. Recently, Rep. Al Ullman (D-Oregon; Chairman of the House Ways and Means Committee), called for a Statewide demonstration project based on Project Health.

Robb, Suzanne S., Peterson, Mark, and Nagy, Joseph W., Jr., "Advocacy for the Aged," *American Journal of Nursing*, Vol. 79, No. 10, October 1979, pages 1736-1738.

"Advocacy is a role available to nurses that offers an exciting and challenging opportunity to act as independent professionals to bring about change within the system." In this article, the authors describe the advocacy role taken by three employees at Kane Hospital, a 2,200 bed nursing home in Pittsburgh, Pa. and the second largest facility of its kind nationwide. Deplorable conditions at the facility led the three employees to resign and to publish a report, *Kane Hospital, A Place to Die,* describing the conditions. The three then enlisted community support from Kane employees, patients' families, religious, labor, community and professional groups, and formed the Committee to Improve Kane Hospital. The Committee's activities and report led to a U.S. Senate hearing by the Committee on Aging's Subcommittee on Long Term Care, resulting in mass media attention and public outcry at the atrocious conditions at Kane. The authors suggest that the Committee's strategies used over a two year campaign could prove effective for other advocacy groups in similar situations. The Committee's pressure resulted in new admissions to Kane being banned by the Pennsylvania Health Department. The authors report an outstanding victory in that significant improvements were made at Kane. "Advocacy is no task for the uncommitted," the authors state, and they provide a convincing argument that the potential results are well worth the effort.

Butler, Patricia A., *Nursing Home Quality of Care Enforcement,* Parts I and II, Legal Services Corporation, November 1979.

In Part I, Litigation by Private Parties, the author begins by stressing the need for defining quality of care "beyond the absence of negligence and the presence of some level of protection," something she feels has not yet been satisfactorily accomplished. Ms. Butler then explores the numerous mechanisms available to nursing home residents and their representatives to enforce and protect their right to quality care. These include, for example, Federal Medicaid/Medicare survey requirements for certification and decertification; State licensure requirements; direct legal action by residents; and community intervention.

Part II, State Agency Enforcement Remedies, explores the legal processes of receivership, penalties and fines, and injunctions. She asserts that the effectiveness of penalty/fine systems cannot be assessed without additional research. The subject of criminal sanctions is also explored.

The author concludes that to enforce quality of care, it is necessary: to improve nursing home standards by redirecting them to patient care, rather than structural soundness; to provide States with a secure legal base for enforcement; and for quality of care advocates to support enforcement efforts. The author also recommends further research into enforcement methods.

"Issues in Deinstitutionalization," *Human Services Bibliography Series,* PROJECT SHARE, HEW, OASPE, April 1978.

This bibliography is comprised of selected annotated citations of documents within the PROJECT SHARE collection, relating to alternatives to institutionalization. (PROJECT SHARE is a national clearinghouse for improving the management of human services.) Among the topics included are comprehensive care to the elderly, costs of homemaker-home health aide services, dependent and neglected children, day care for older people, and mental health services. The bibliography is available free of charge from the Publications Office, PROJECT SHARE, P.O. Box 2309, Rockville, Maryland 20852.

Housing for the Elderly and Handicapped, The Experience of the Section 202 Program from 1959 to 1977, U.S. Department of Housing and Urban Development, HUD Publication No. PDR-301, January 1979.

This lengthy and detailed report is HUD's first attempt at evaluating the operation and effectiveness of the Section 202 program—one of the first Federal programs designed specifically to meet the housing needs of elderly and handicapped persons. The authors thoroughly analyzed and compared subsequent elderly subsidy housing programs, including Sections 236, 202/8, and 231. They evaluated the programs in terms of tenant characteristics, project locations, program and project administration, project physical characteristics, cost effectiveness, subsidies and rent reductions. They conclude the Section 202 program was probably more effective than the other programs because it produced financially viable, high quality housing projects. It did this so successfully because: it produced good housing for the elderly that was acceptable to tenants and communities; its projects were usually sponsored by capable non-profit organizations in convenient neighborhoods and were directed by qualified administrators; it provided these resources at a cost comparison favorable to other programs. The authors analyze the different aspects of the programs which led to some being more effective. They report that their findings provide insights into the factors that constrain and influence the outcome of any program designed to provide multi-family housing. They add that the features of some programs which lend themselves to success cannot always be replicated in new legislation.

Naylor, Harriet H., "Volunteers, Resources for Human Services," *Occasional Paper Series*, PROJECT SHARE, HEW, OASPE, 1979.

Health care and human service managers face public pressures to deliver cost effective, appropriate, and quality services to their clients. This paper is intended to help the executive tap volunteer resources to deal with these pressures. The author explores the myriad of volunteer roles within a conceptual framework of citizen participation, advocacy, and direct service delivery. Volunteers, for example, are involved in all aspects of health care including prevention, treatment, acute care, rehabilitation, long term care, mental health, drug abuse, clinics, and immunization projects. Naylor discusses the separate, but complementary roles of the executive and the professional director of volunteers. She presents resource organizations for volunteer administrators, and the status of Federal and State volunteer programs. A glossary and bibliography are also included.

PROJECT SHARE, a national clearinghouse for improving the management of human services, offers single copies of this publication free of charge from the Publications Office, PROJECT SHARE, P.O. Box 2309, Rockville, Maryland 20852.

"Dental Care For Handicapped Americans," *Special Report*, The Robert Wood Johnson Foundation, No. 2, 1979.

This special report focuses on problems of inadequate dental care for approximately 33,000,000 Americans who are mentally or physically handicapped. Dental care is difficult to obtain for these individuals because treatment problems typically relate either to management of the patient's medical problem, or management of their physical limitations. Many medical problems of the handicapped contribute to their dental problems, causing them to need constant dental care. For example, individuals having epilepsy take drugs to control seizures, but the drugs in turn induce excessive growth of gum tissue which has a tendency to become infected; people with cerebral palsy suffer from grinding their teeth. Patient management includes: transferring patients from wheel chair to dental chair; being prepared for seizures when treating epilepsy patients; caring for the cerebral palsy patients plagued with continual movements, or mentally retarded patients with short attention spans and high levels of anxiety. The special needs of handicapped individuals have presented challenges for dentists.

Changes in dental practices and education in the past decade are leading to growing sensitivity and awareness of the needs of the handicapped. The report examines the experiences of a few dentists specializing in treating this population. It points out the principal problems that must be overcome if America is to provide adequate dental care to its handicapped, and discusses the National Foundation of Dentistry for the Handicapped efforts and goals. Strides many dental schools have taken in improving dental students' technical capabilities and philosophical approach to treating handicapped patients, and the need to teach the handicapped individual how to care for their own dental needs are also discussed.

Daniels, Robert S., M.D., "Comparison of National Health Insurance Systems, Who Has the Answers?" *The Ohio State Journal,* Vol. 74, No. 10, October 1978, pages 643-645.

The author studied health delivery systems in England, Scotland, Russia and Canada to make observations concerning the impact of a universal or national payment plan on medical care. Certain problems, issues and opportunities emerge as common to all systems. The problems reflect the socioeconomic-political system of the country; how an individual may seek help and whether society is responsible for any or all of that service, and reimbursement of professionals and allied individuals delivering the services. These observations may be of value due to current emphasis on national health insurance in the United States.

All systems are examining the question of cost effectiveness, but are finding it difficult to do so rationally. Not only is the social and economic cost of illness and disability hard to evaluate, but it is "almost impossible to compare today's costs with those of a few years ago when the patient would have been disabled or have died." Most political leaders advocate holding expenditures at a constant, and redistributing the resources to meet new objectives. However, Daniels states, if expensive technical innovations may save or sustain life, the question remains how individuals are chosen to receive such care.

Daniels concludes, should the U.S. undertake a national health insurance program, some common expectations are not likely to occur: (1) such a plan will not be developed suddenly; (2) initially, the status quo will be maintained; (3) patients will continue to return to the physicians and the settings in which they previously were served; (4) the initial cost of the plan will be great with gradual tapering off; and (5) distribution and function of personnel will not be drastically altered.

Brazda, Jerome F., "EC Health Insurance, What Americans Can Learn From Europe," *Europe,* September-October 1979, pages 44-47.

In efforts to plan national health insurance, U.S. officials and health professionals have been examining national health plans operating in Europe. The author reveals some findings, and outlines health systems of nine countries belonging to a European Community (EC). Following this article, *Europe* staff writer Marcia Miller details recent EC actions toward a common health policy, and summarizes an EC regulation which guarantees health care for insured citizens living or traveling in other member countries.

According to the article, HEW experts found Germany's health insurance system most similar to the U.S. system, with a striking parallel in inflation rates of medical prices over the past ten years. Major problems observed were absence of patient cost sharing, which, the experts believe, contributes to overutilization, and the absence of provider incentives to hold down costs. Norway's system, the experts feel, is among the most comprehensive and best organized in the world. There, health insurance is provided through a single, Federally administered fund with services delivered through government owned and administered hospitals, clinics, and health centers. That system works through local governments and the national physicians' association; physicians' services are subject to a flexible copayment. In addition, all hospital care is free.

Kaercher, Dan, "HMOs: Could they Keep Health Care Down?" *Better Homes and Gardens,* February 1980, pages 29-34.

Prepaid health care plans, Health Maintenance Organizations (HMOs), may be a way of coping with mounting health expenses. HMOs have an economic incentive to keep their members well because they work within a budget established by prepayments. Members are encouraged to receive periodic checkups and see physicians whenever they are ill. Based on a fixed monthly fee (sometimes paid by employers), members are entitled to practically every medical service except, usually, house calls. HMO services are provided by a preselected group of doctors and hospitals, length of hospital stays are unlimited, and there are no surgery fee schedules, deductibles or coinsurance.

Some eight million Americans participate in over 230 HMOs which are run by such diverse groups as doctors, labor unions, insurance companies, and the Federal government. This article indicates that even though HMO premiums exceed health insurance premiums, HMO participants' health costs are less, due to fewer out-of-pocket expenses and less time spent in hospitals.

Public awareness of HMOs is low; many people view HMOs as glorified public clinics and they do not want to leave their family physician. The author adds that many physicians do not participate in HMOs because they don't like other doctors reviewing their work, they prefer not to be salaried, and they dislike the HMO competition concept.

The article concludes with discussions about what to look for when choosing an HMO, how to join an HMO, and a description of Minneapolis-St. Paul's experience with HMOs.

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